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ENGINEERING ISSUE

HOSPITAL Management

THE JOURNAL FOR ADMINISTRATORS AND DEPARTMENT HEADS

THE UNIVERSITY OF MICHIGAN
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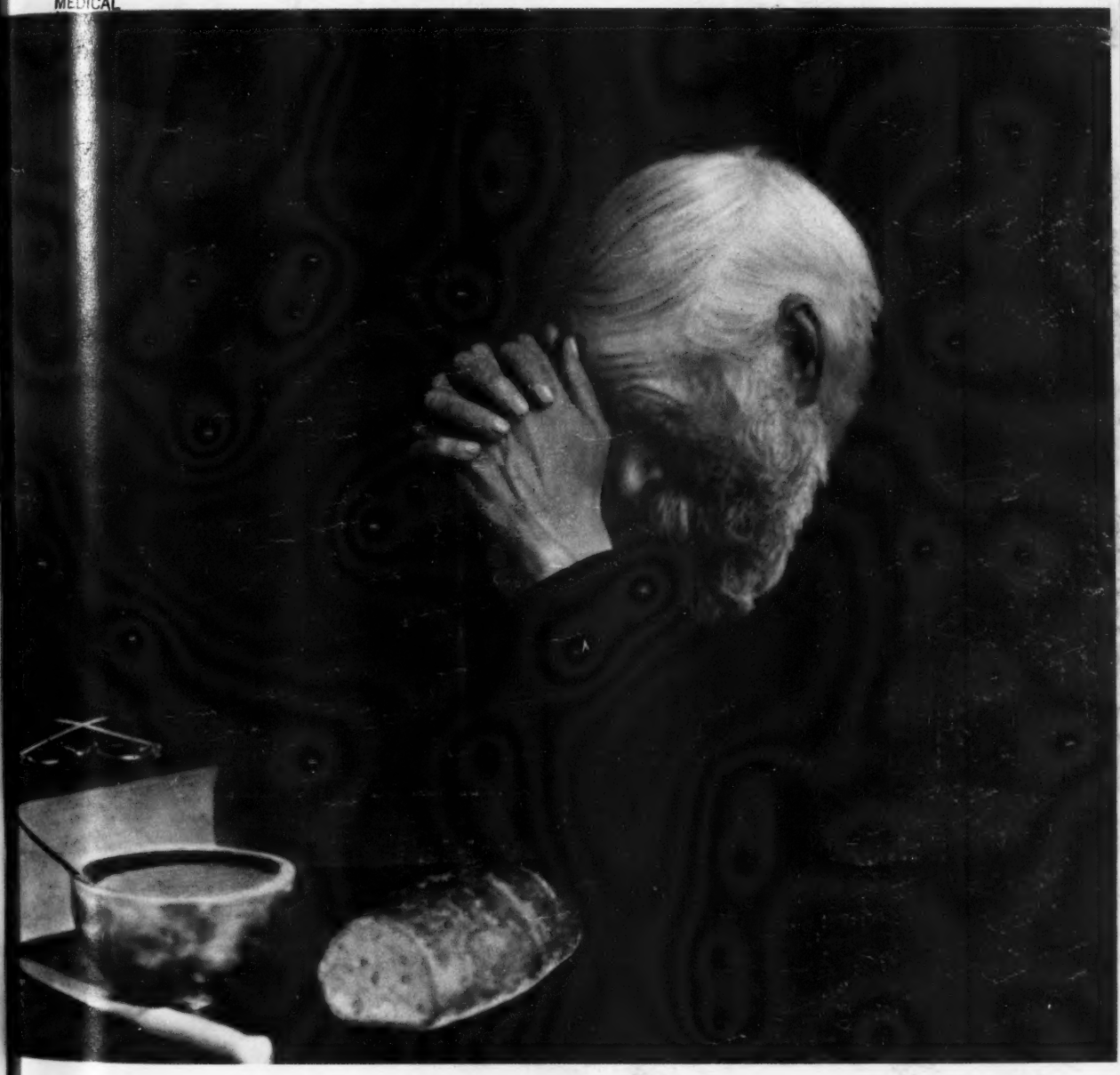

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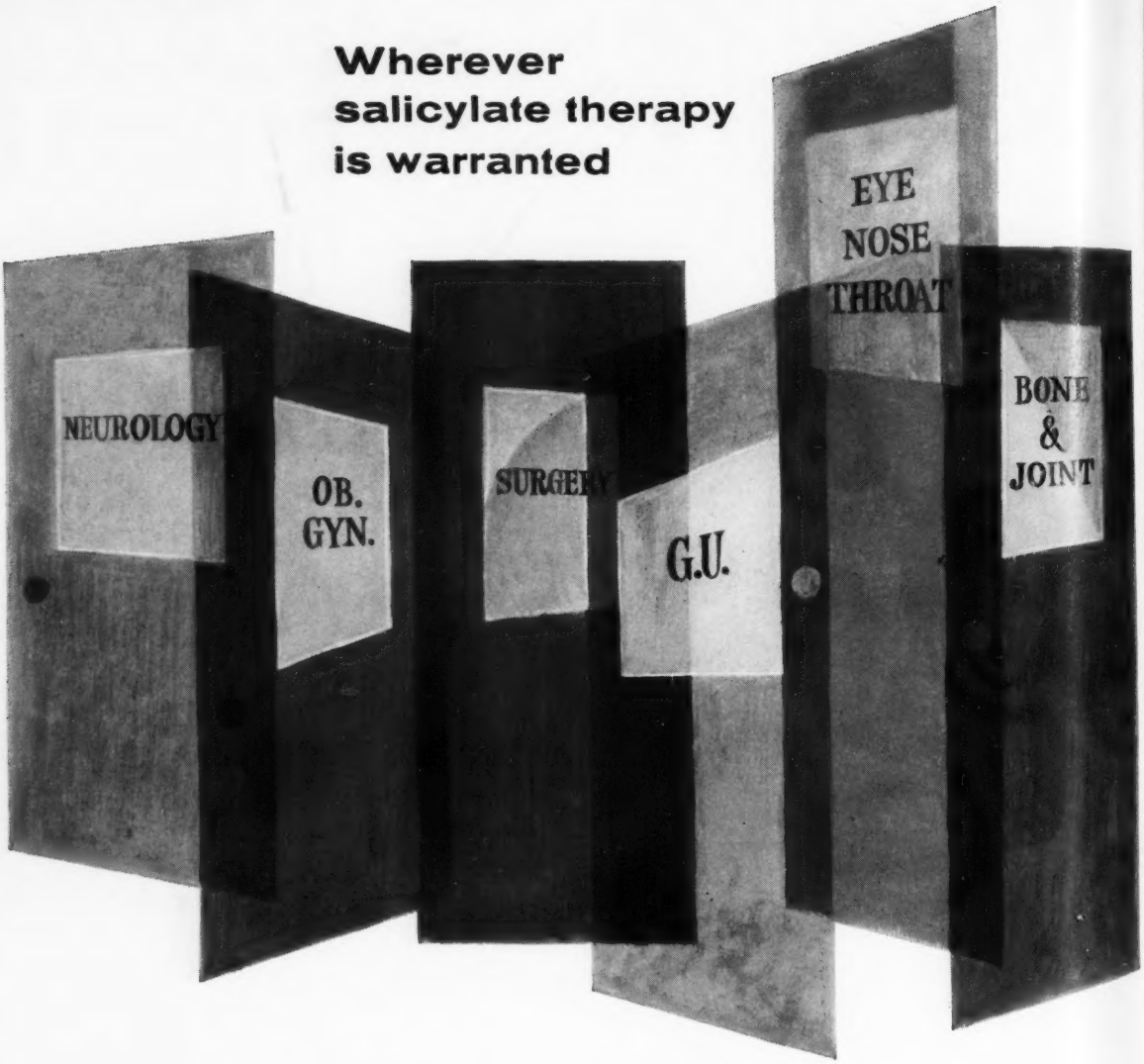

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Small Hospital's Clinic

The Small Hospital and the X-Ray Technician

Sister Mary Edmund, R. T.

St. Helen Hospital
Chehalis, Wash.

■ THE PURPOSE of this paper is not to expound something unique and new in x-ray techniques. The aim is to bring to the reader the position of the small hospital in modern living and the x-ray technician as part of its functioning.

With the modern trend toward suburban life there has been an increase in the number of small hospitals to care for the needs of these new communities. Of the 124 hospitals belonging to the Washington Hospital association, 75, or more than 61 percent are small; that is, having less than 100 bed capacity.

According to the April issue of the "Washington Hospitals," about 26 percent of the small hospitals of this state have the approval of the Joint Commission on Accreditation. Since St. Helen Hospital has full accreditation, remarks will be made concerning this type of institution.

Facilities for radiographic, fluoroscopic, and portable radiography are available to the physician at all times, however, very rarely is the fluoroscope used by anyone other than radiologists. As a rule, the films are developed while the patient is in the x-ray department, except for the miniature chest films taken on admission. The department handles an average of 170 patients a month, not including patients for admission chest x-rays. Of this number about 70 percent are outpatients.

The room in which the radiographic and fluoroscopic work is done is lead lined throughout. A control stand is built to protect the technician during exposures. Lead aprons and gloves are available to the radiologist and the technicians. Cones and other protective materials are also used whenever possible. During the past two years protective aprons have been used extensively in chest x-ray work.

The machinery is well grounded to prevent shock and the processing room is arranged in such a way that cassettes and films are handled with least danger of damage to exposed and unexposed film.

The services of the radiologist are available two days a week, Tuesday and Thursday. All gastro-intestinal studies, myelograms, bronchograms, uterosalpingograms, and the like are scheduled for these days. At this time all the radiographs taken during the week are interpreted and the reports are made available to the referring physicians as soon as possible. On Wednesday a specialist in gynecology examines patients and supervises retrograde pyelography. Intravenous pyelography is done at the convenience of the attending physician, who injects the contrast media and who is readily available should drug reactions occur.

The radiologist is consulted by the medical staff on cases of special import. In emergency cases radiographs are sent to the radiologist by bus and the interpretation is made directly to the physician by telephone. The written reports are made later. Triplicate copies of each

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report are made. The original is signed and filed with the patient's chart. One copy is sent to the referring physician and the last copy is filed in the department. On occasions when extra copies of reports are needed they are provided. Before filing, the reports are indexed according to region of body and disease. This index has been very useful in reviewing unusual cases or when comparison with previous examinations has been found necessary.

Patients requiring deep or superficial therapy are treated in Olympia which is about a half an hour's drive from Chehalis. Observation of post therapy is made by appointment in the department.

At least one registered x-ray technician is necessary in an x-ray department. On some days it may be required that a technician help in other departments if it is convenient. A knowledge of one or two associated fields is found helpful and rewarding. Medical records librarian and medical secretary are two excellent complementary fields for an x-ray technician in a small hospital. A nursing career is invaluable if coupled with that of an x-ray technician. Each of these careers helps to develop a well-rounded personality and each has its own scope of interesting activities to fill the days with unselfish devotion for the welfare and care of the sick and the injured. The x-ray technician in a small hospital faces a challenge that calls for a generous person who seeks rewarding work. ■

Let's Play It Safe

For use of the safety illustrations in this issue appreciation is expressed to the Wesley Memo of Chicago Wesley Memorial Hospital.

WRONG: To remove the lid by putting finger in the juice and by cutting a thumb or finger on the sharp edge.

RIGHT: Remove the lid from the can with the aid of a knife.

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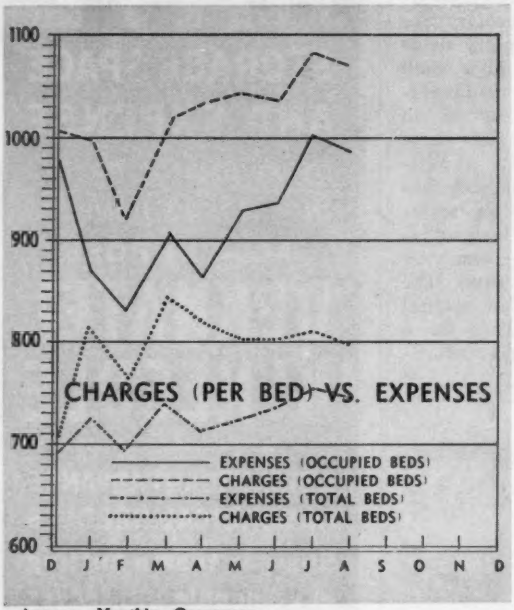
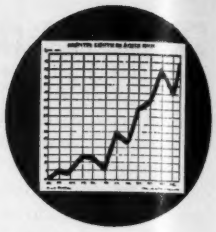




■ TO TEST THE INFLUENCE of "How's Business" on hospital accounting and statistics we inquired from our sample what action, if any, the administration took when the hospital varied appreciably from averages published in HOSPITAL MANAGEMENT.

Twenty-five percent reported action which, for the most part, amounted to an analysis of a department out of line. Justification is sought for higher expenses and, if none can be found, changes may be made. But most reported a "see what next month shows" attitude before taking action.

Although no reason was asked of those replying "no" to the question, a substantial number reported that no action was called for because they were consistently below the averages reported.

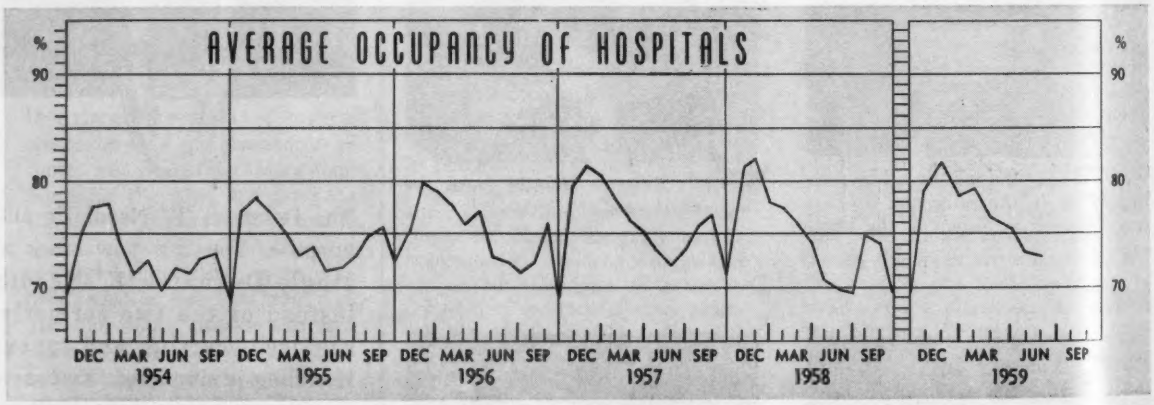
The sample is limited to short-term, non-federal, general hospitals which number 4982 in the U. S. according to the American Hospital Association. On October 5, 1959, 1511 hospitals or 30% of all general, short-term, non-federal hospitals in the U. S. were participating in How's Business. ■

Average Monthly Occupancy
(on 100 percent basis)

January, 1958	80.98
February, 1958	81.97
March, 1958	77.84
April, 1958	77.20
May, 1958	76.10
June, 1958	74.15
July, 1958	70.78
August, 1958	70.01
September, 1958	69.69
October, 1958	74.99
November, 1958	74.30
December, 1958	69.45
January, 1959	79.00
February, 1959	81.42
March, 1959	78.94
April, 1959	79.25
May, 1959	76.45
June, 1959	75.58
July, 1959	73.11
August, 1959	72.92

Average Length of Patient Stay
(in days)

October, 1958	6.8
November, 1958	7.0
December, 1958	6.8
January, 1959	7.1
February, 1959	7.2
March, 1959	6.8
April, 1959	6.9
May, 1959	7.0
June, 1959	6.4
July, 1959	6.6
August, 1959	6.6



Average Operating Expenses Per Occupied Bed Per Month

January, 1958	811.72
February, 1958	788.06
March, 1958	896.46
April, 1958	862.87
May, 1958	885.02
June, 1958	888.85
July, 1958	945.39
August, 1958	948.40
September, 1958	929.24
October, 1958	944.18
November, 1958	897.07
December, 1958	979.27
January, 1959	873.70
February, 1959	833.68
March, 1959	903.46
April, 1959	867.97
May, 1959	928.66
June, 1959	935.96
July, 1959	1002.53
August, 1959	986.75

Average Patient Charges Per Occupied Bed Per Month

January, 1958	918.10
February, 1958	862.21
March, 1958	1003.77
April, 1958	950.00
May, 1958	971.78
June, 1958	960.07
July, 1958	1002.61
August, 1958	999.23
September, 1958	972.16
October, 1958	1020.53
November, 1958	946.90
December, 1958	1002.51
January, 1959	992.15
February, 1959	924.74
March, 1959	1035.52
April, 1959	1034.43
May, 1959	1041.00
June, 1959	1039.85
July, 1959	1082.56
August, 1959	1069.64

Average Operating Expenses Per Bed Per Month (Total Beds)

January, 1958	675.67
February, 1958	665.96
March, 1958	700.18
April, 1958	678.17
May, 1958	686.88
June, 1958	666.07
July, 1958	676.46
August, 1958	677.66
September, 1958	652.33
October, 1958	725.25
November, 1958	678.97
December, 1958	695.15
January, 1959	728.91
February, 1959	697.25
March, 1959	747.24
April, 1959	714.10
May, 1959	726.04
June, 1959	732.93
July, 1959	752.94
August, 1959	744.31

Average Patient Charge Per Bed Per Month (Total Beds)

January, 1958	761.39
February, 1958	727.58
March, 1958	784.75
April, 1958	743.49
May, 1958	754.21
June, 1958	719.44
July, 1958	717.40
August, 1958	711.1
September, 1958	679.01
October, 1958	780.03
November, 1958	714.10
December, 1958	709.37
January, 1959	814.98
February, 1959	769.30
March, 1959	846.19
April, 1959	824.37
May, 1959	806.15
June, 1959	805.50
July, 1959	810.36
August, 1959	794.66

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REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,288	3,881	9,680	1,470	3,683	9,314	1,530	3,807	8,862	1,248	4,255	8,773
% of OCCUPANCY	61.09	77.47	73.68	71.44	72.81	81.60	68.94	81.43	80.70	63.50	76.38	78.78
EXPENSES BY DEPTS. Per Patient Day												
Administration	4.15	4.85	5.52	3.97	2.86	3.51	2.88	3.33	2.97	3.63	3.08	3.59
Dietary	3.78	4.62	4.83	3.76	3.33	3.50	3.08	3.22	2.87	3.00	3.04	3.42
Housekeeping	1.56	1.84	2.27	1.40	1.26	1.47	1.11	1.16	1.15	1.20	1.11	1.48
Laundry	.94	.82	.69	.76	.69	.60	.60	.64	.49	.69	.70	.45
Plant Operation	1.67	2.51	2.89	1.96	1.74	1.91	1.75	1.60	1.82	2.13	2.00	1.93
Medical & Surgical	1.08	1.68	2.67	1.44	1.24	1.67	1.21	1.74	2.04	1.79	1.39	2.33
O. R. & Del. Rms.	2.60	2.30	2.12	1.93	1.67	1.42	1.40	1.79	1.89	1.80	2.21	2.37
Pharmacy	1.39	1.39	.98	1.52	1.20	1.31	1.45	1.52	1.72	1.83	1.92	1.82
Nursing	8.70	8.84	7.78	8.18	6.68	6.54	6.77	6.36	5.11	6.70	6.52	6.68
Anesthesia	1.13	.92	1.03	.61	.44	.85	.61	.64	.63	.60	.67	1.11
Laboratory	2.21	2.59	2.71	2.23	1.91	2.14	1.39	1.81	1.90	2.04	2.54	2.76
X-ray	2.01	2.10	1.70	1.76	1.57	1.42	1.62	1.39	1.60	1.27	1.68	1.66
Other expenses	1.59	.99	2.36	.54	.82	1.46	.57	.68	1.26	.60	1.04	1.25
TOTAL EXPENSES	41,688	140,692	378,731	42,766	94,115	267,506	36,627	99,087	231,836	33,479	121,079	274,684
TOTAL CHARGES TO PATIENTS	41,111	147,147	377,243	46,816	102,096	307,856	38,790	111,555	261,701	36,375	139,575	319,612
OPERATING INCOME PER PATIENT DAY	31.92	37.92	38.97	31.85	27.72	33.05	25.35	29.30	29.53	29.15	32.80	36.43
OPERATING EXPENSES PER PATIENT DAY	32.37	36.25	39.13	29.09	25.55	28.72	23.94	26.03	26.16	26.83	28.46	31.31

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan, Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,275	3,318	8,557	978	3,551	8,427	1,128	3,775	7,440	1,319	3,475	6,640
% of OCCUPANCY	65.08	70.84	82.29	62.91	71.00	78.97	76.15	69.27	82.12	63.23	65.97	74.38
EXPENSES BY DEPTS. Per Patient Day												
Administration	3.74	3.89	3.91	2.41	2.75	3.80	2.88	5.93	3.25	5.45	6.15	5.85
Dietary	3.55	3.75	3.76	2.92	3.63	3.48	2.77	4.08	4.01	5.18	4.68	4.36
Housekeeping	1.27	1.64	1.67	1.05	1.46	1.54	.99	1.42	1.37	2.57	2.45	2.38
Laundry	.78	.74	.69	.64	.73	.61	.84	.78	.73	1.36	1.17	.97
Plant Operation	1.94	2.01	2.00	1.84	1.93	2.11	1.40	1.65	1.54	3.01	2.62	2.07
Medical & Surgical	1.60	1.62	2.81	1.60	2.51	2.29	2.27	1.55	2.20	1.43	2.32	2.79
O. R. & Del. Rms.	1.60	2.27	1.77	1.64	2.39	1.94	1.15	2.07	2.30	5.86	3.46	4.25
Pharmacy	1.61	1.49	1.42	1.32	1.39	1.80	2.12	1.45	1.64	2.38	1.90	1.80
Nursing	8.48	7.66	7.65	7.27	6.53	6.86	7.88	10.32	7.81	12.62	12.25	13.15
Anesthesia	.90	.66	.55	.44	.44	.59	.06	.70	.29	.49	.82	.56
Laboratory	1.48	2.18	2.22	1.25	1.83	2.63	1.34	2.69	1.88	3.57	3.19	3.81
X-ray	1.76	1.95	1.67	1.10	1.57	1.72	1.73	2.83	1.51	1.96	2.02	2.24
Other expenses	.35	.39	1.31	.54	.65	1.45	.65	.84	1.12	3.21	2.46	1.21
TOTAL EXPENSES	35,891	100,647	271,473	22,134	99,060	264,001	27,060	138,169	216,956	64,039	156,926	300,906
TOTAL CHARGES TO PATIENTS	37,281	107,133	302,205	22,841	105,112	271,836	31,548	134,768	225,395	61,822	154,476	321,192
OPERATING INCOME PER PATIENT DAY	29.24	32.29	35.32	23.35	29.60	32.26	27.97	35.70	30.30	46.87	44.45	48.37
OPERATING EXPENSES PER PATIENT DAY	28.15	30.33	31.72	22.63	27.90	31.33	23.99	36.60	29.16	48.55	45.16	45.32

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Time-tested OXYCEL (oxidized cellulose, Parke-Davis) promptly achieves surgical hemostasis following capillary and other small-vessel bleeding. Applied directly from the container, OXYCEL readily conforms to wound surfaces.

■ Sterilized, gauze-type, 3 inch x 3 inch eight-ply pads, and 4 inch x 12 inch eight-ply pads.

▬ Sterilized, cotton-type, 2½ inch x 1 inch x 1 inch portions.

▬ Sterilized, four-ply, gauze-type strips, 5 inch x ½ inch, 18 inch x 2 inch, 36 inch x ½ inch, and 3 yard x 2 inch, pleated in accordion fashion.

▲ Sterilized, four-ply, gauze-type discs, 3 inch and 5 inch diameters, conveniently folded in radially fluted form.

Supplied in individual glass containers.

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It requires more than a simple process to make sterilizer controls. That's why no imitation of Diack Controls has ever produced what the hospitals need — a simple, foolproof method of proving sterilization.

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Go back to the first principles of cleanliness and sterility and you will control the staph problem.

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SMITH & UNDERWOOD, Royal Oak, Michigan . . . . Sole manufacturers of Diack Controls and Inform Controls

TIME-TRIED Diack Controls

Hospital Accounting

with Professor T. LeRoy Martin

When Is A Dividend Considered Expendable Income

Inquiry:

The statement has been made that not all dividends on investments are expendable income. This appears significant in its relationship to accurate accounting for hospital income. The matter is further complicated by the receipt of a stock dividend on stock held as investments. Is there a general rule applicable?

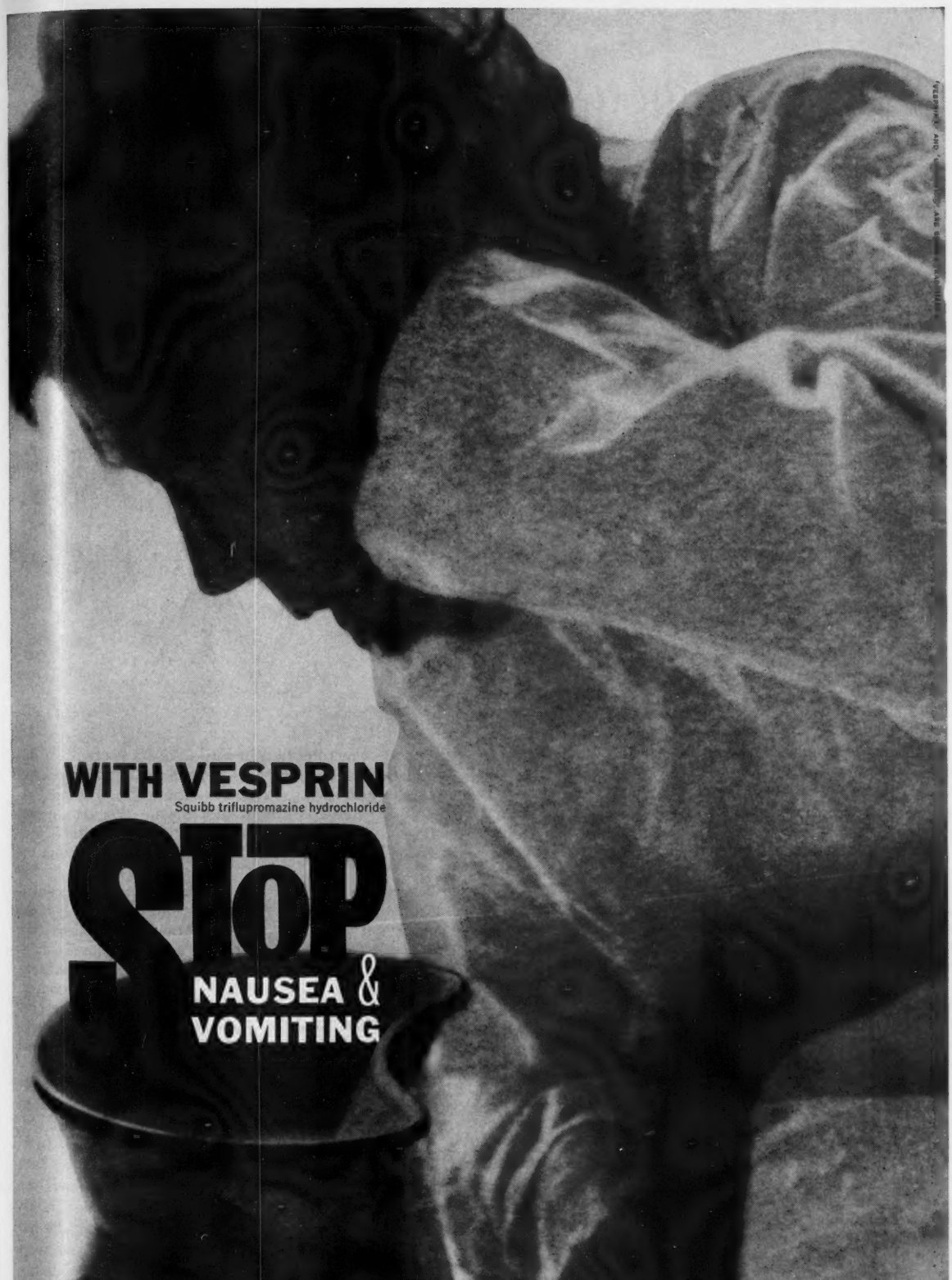
Comment:

The general rule is that cash dividends received on investments in corporation stock represent expendable income. The principal exception to this rule relates to dividends from income earned by the hospital. In theory, a dividend paid from earnings by the corporation prior to the acquistion date of the stock investment is a return of investment and not income. In practice this point is usually disregarded and such dividends are considered income to the recipient. It also appears that the various state statutes may differ in the legal classification of such dividends. In some states it appears that the legal rule is that dividends are income when received in cash regardless of the date of declaration or the time when the earnings from which the dividend is paid were realized. If a particular state does not have an applicable statute, the answer may be found in court decisions applicable to dividends received within the state. No cases of litigation in relation to this matter have come to the attention of the writer so it must be assumed that the problem of determining whether a particular dividend is expendable income is not a matter which has been contested. The amounts involved are usually immaterial and therefore the practical importance is not great.

Stock dividends present a slightly different problem. Usually a stock dividend results in no realization of income. The usual result is that the cost basis of the investment in stock must be split up between the original stock and the stock received as a dividend. For example, if a hospital has 100 shares of X Corporation common stock, and if X Corporation has outstanding only common stock, then a stock dividend paid in common stock on the common stock held is not income. The corporation has merely capitalized some retained earnings, earnings which already belonged to the common stockholders, and the net result is that the stockholder institution has more shares of stock than before but the total value of all shares held after the dividend is the same as the total value of the fewer shares held before the stock dividend.

Expendable income is received when a stock dividend results in the stockholder institution having a greater financial interest in the corporation than it had prior to the receipt of the dividend. For example, if a hospital owned preferred stock in Y Corporation and received common stock as a stock dividend on the preferred stock, its financial interest in the corporation is increased thereby and income results. If the preferred stock is the noncumulative, nonparticipating type, under which conditions the stock represents no interest in retained earnings, the market value of the stock received as a dividend is considered expendable income. ■

For more information, use yellow postcard inside back cover.



Dosage: Intravenous, 5 to 12 mg. / Intramuscular, 5 to 15 mg. / Oral prophylaxis, 20 to 30 mg. daily / **Supply:** Tablets, 10, 25, and 50 mg., bottles of 50 and 500 / Emulsion, 30-cc. dropper bottles and 120-cc. bottles (10 mg./cc.) / Parenteral Solution, 1-cc. multiple dose vial (20 mg./cc.) / 10-cc. multiple dose vial (10 mg./cc.) / Vesprin Injection Unimatic (15 mg. in 0.75 cc.)

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'HM' Salutes

Robert Wood Johnson

Chairman of the Board of
Johnson and Johnson
New Brunswick, New Jersey

■ ROBERT WOOD JOHNSON is one of those fabulous Americans who have made our country a better place in which to live. In particular, he has helped to make hospitals safer and more efficient. In his way he has saved many sick and injured people by his efforts.

He is presently chairman of the board of Johnson and Johnson, a firm which manufactures hospital supplies. He has combined business interests with public service in a manner which few businessmen have ever done. In addition to his business achievements, he has a magnificent record of public service. During World War II he served in the U.S. Army and was honorably discharged in 1943 with the rank of Brigadier General. It was in 1943 also that he was appointed by President Franklin D. Roosevelt as vice chairman of the War Production Board and chairman of the smaller war plants corporation.

He was born in New Brunswick, New Jersey and entered the family firm of Johnson and Johnson at the age of 17. In 1918 at the age of 25 he became a manager of the Borough Council of Highland Park, New Jersey and two years later he served as its mayor. He became interested in hospitals very early in life. In 1915 at the age of 22, he served as chairman of the executive committee of Middlesex General Hospital in New Brunswick and in 1921 he became president of this institution in which capacity he served for six years.

Perhaps his greatest contribution to hospitals has been his work with the Society for the Advancement of Management which enabled hospitals to adopt many time and labor saving practices being used in industry. As a hospitalized patient, General Johnson noted many shortcomings in management practices which would not have been tolerated in business. As a result of this experience, he assembled numerous skills to give expert advice to hospitals gratuitously. From the Raritan Valley, where his experiment first began, the idea spread rapidly throughout the United States. The hospital program of S.A.M. is now established in many parts of the country.

One of the least known of General Johnson's contributions to the hospital field is the initial financing of the Program in Hospital Administration at Northwestern University through the Johnson and Johnson Foundation. It was to General Johnson that Doctor MacEachern turned for assistance in starting this program. In addition to providing the financial support for the program, the Johnson and Johnson Foundation also provided money for scholarships for students in hospital administration.

General Johnson has written several books and articles on business practices and is widely hailed as an authority on human relations in business.

For his magnificent record of public service, General Johnson has been awarded many decorations by such organizations as the American College of Surgeons, the Public Relations Society, the Freedoms Foundation and the American Hospital Association. In addition, he has received the honorary degree of Doctor of Laws from Rockhurst College in Kansas City, Rutgers University in New Brunswick and Northwestern University in Chicago.

HOSPITAL MANAGEMENT is proud to add its humble salute to the growing list of honors bestowed upon this fine citizen. ■

Before Esidrix:
Weight 176 lbs.

27 pounds lost in 19 days; ascites and pedal edema reduced with

Esidrix T.M.

(hydrochlorothiazide CIBA)

pre-eminently effective whenever diuresis is desired

Indicated in: congestive heart failure ■ nephrosis and nephritis ■ toxemia of pregnancy ■ premenstrual edema ■ edema of pregnancy ■ steroid-induced edema ■ edema of obesity.

RECORD OF TREATMENT (At a leading New York City hospital. Photos used with permission of the patient.)

Date	3/3	3/4	3/5	3/6	3/7	3/8	3/9	3/10	3/11	3/12	3/13	3/14	3/15	3/16	3/17	3/18	3/19	3/20	3/21	3/22	3/23
Weight (pounds)	178	176	170	169	167	159	158	158	157	153	155	155	156	154	153	154	153	—	—	151	149
Rx	M*		Esidrix 50 mg. b.i.d.																		

*Mercurial diuretic

After 19 Days on Esidrix:
Weight 149 lbs.

H. K., 44 years old, with history of heavy drinking. Previously hospitalized in 1954, with diagnosis of Laennec's cirrhosis. Admitted on 3/3/59, patient complained of swollen abdomen, swelling in both legs and exertional dyspnea.

Findings: Abdomen enlarged in girth with definite fluid wave; liver palpated 4 fingerbreadths below the costal margin; pedal edema (4+). Patient not in acute distress. Blood pressure, 140/80 mm. Hg; pulse, 112/min.; respiration, 20/min.

Treatment: Mercurial diuretic on 3/3 and 3/4, followed by Esidrix, 50 mg. b.i.d., from 3/5 to 3/23 when patient signed out of hospital. Esidrix induced copious diuresis resulting in almost complete disappearance of edema.

Supplied: Esidrix *Tablets,* 25 mg. (pink, scored) and 50 mg. (yellow, scored); bottles of 100 and 1000.

CIBA

R/2713MK

Consulting

with Dr. Letourneau

Poison Emergencies

QUESTION: *We have had several cases recently where small children have drunk or eaten poison. The hospital does not have interns and we have followed the practice of calling a pediatrician and receiving instructions by telephone. In most instances the nurse administers a gastric lavage and discharges the child who goes home without seeing a physician. Some of our nurses are objecting to these procedures and one nurse recently refused to wash out a stomach without the presence of a physician. What should we do in the future?*

ANSWER: It may be proper for the nurse to initiate a gastric lavage in an emergency following a telephone order by a physician. But the child should not be discharged from the emergency room until he has been examined by a licensed doctor of medicine.

Week End Passes

QUESTION: *We are plagued by patients who want to go home for week ends. As a result of an unhappy experience, we are now asking both the physician and the patient to sign a form permitting the patient to leave and absolving the hospital from liability. What do you think of this practice?*

ANSWER: I think this is an excellent practice and would recommend it highly to all hospitals which have this problem.

Medical Records Education

QUESTION: *Where can I obtain a correspondence course for medical record librarians?*

ANSWER: You should write directly to the American Association of Medical Record Librarians, 840 N. Lake Shore Drive, Chicago, Illinois for information.

Disaster Plan

QUESTION: *Our hospital has a written plan for handling mass casualties. We have never had a rehearsal. Is it necessary to have such a rehearsal to get accreditation for the hospital?*

ANSWER: Rehearsals should be held at least twice a year. Failure to have such rehearsals would not necessarily cause a hospital to lose accreditation but it would certainly earn demerits.

Attendance at Medical Meetings

QUESTION: *Our staff doctors insist that the absence of a physician which has been excused by the medical staff should be counted as a presence for purposes of computing percentage of attendance at medical staff meetings. Can you advise us?*

ANSWER: If everyone is in good faith, the excused absence should be counted as attendance. However, this does not guarantee that such excused absences will get by the eagle eye of the surveyor of the Joint Commission on Accreditation of Hospitals. Subterfuges are usually discovered quickly by these trained physicians.

Dead On Arrival

QUESTION: *It has been almost impossible to find a physician to come to the hospital to pronounce death on patients who are brought to the hospital dead on arrival. May a registered nurse pronounce death or should the hospital keep the body until a physician arrives?*

ANSWER: A person who dies before or while being brought to the hospital is not the responsibility of the hospital. He is the responsibility of his own attending physician. If the attending physician can not be found, the case should be referred to the coroner for instructions.

Progress Notes

QUESTION: *One of our physicians has interpreted a paragraph in the book "Hospital Accreditation References" to mean that no progress notes need be written, if the attending physician cannot see a necessity for them. Providing everything else is completed on the chart may such a record be filed by the record librarian?*

ANSWER: It is the doctor's prerogative to write progress notes or not, as he deems necessary. It is understood that the case will be reviewed by the medical records committee before filing. All that remains to be seen is whether or not the surveyor of the Joint Commission on Accreditation of Hospitals will agree that progress notes are unnecessary. If he does not, demerits may accrue to the hospital.

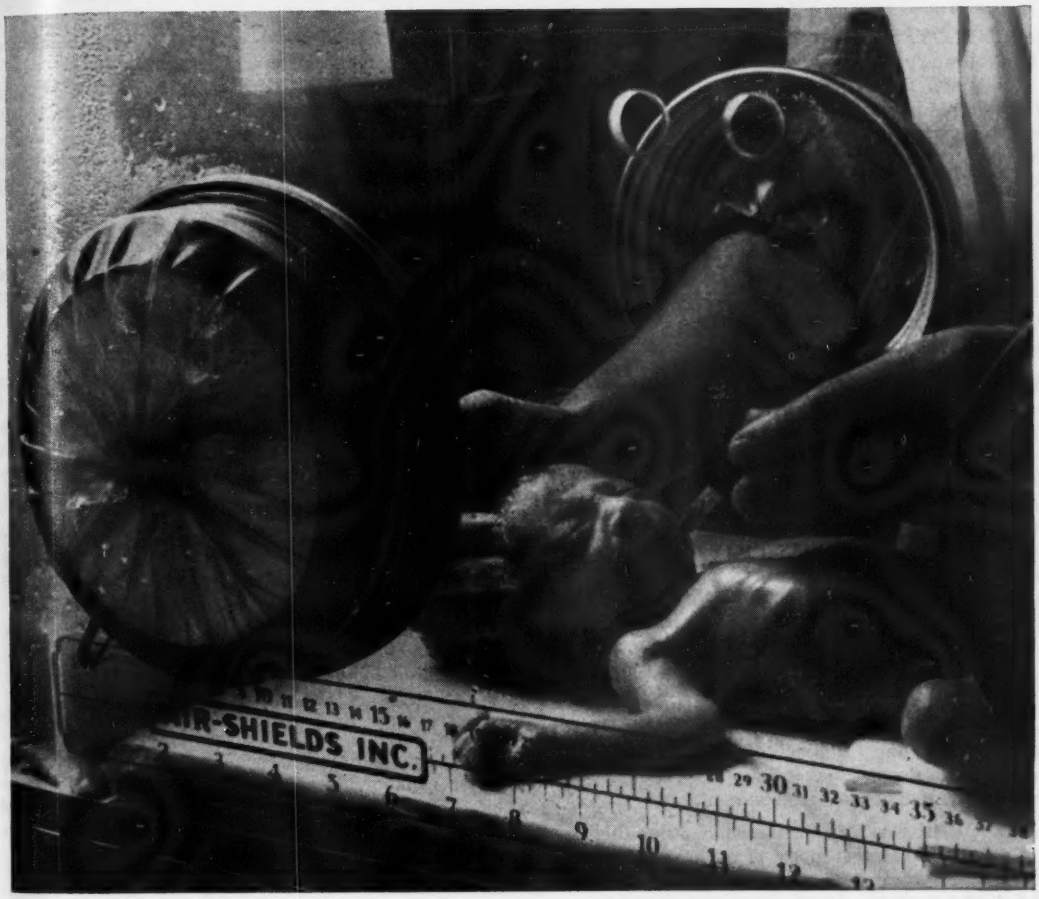
Release of Information

QUESTION: *An attorney on the governing board of our hospital has given his opinion that an authorization signed by a former patient constitutes an order to the medical record department to place all information in the medical record at the disposal of the patient or his representative. The administrator and two members of the board disagree. What is your opinion?*

ANSWER: I also disagree with your attorney. The medical records of the hospital should be treated in the same way as the records of a physician, an attorney, a bank or a stock broker. The authorization by a patient, client or customer does not ordinarily constitute an order to reveal the records, unless there is a law to that effect in your state (e.g. Connecticut).

Some hospitals are now making a duplicate copy of the medical record for the attending physician and all inquiries concerning his patients are referred to him. ■

Greater promise for survival within the "protective shell" of the ISOLETTE®



The ISOLETTE® insures every advantage for survival.

Maximum protection for the tiniest infant requires strict isolation and precise control of the incubator environment. The ISOLETTE® Infant Incubator alone provides these essentials through "well regulated warmth and humidity and economical oxygen concentrations in a convenient working area for nurse and doctor . . . The isolation of the patient from his neighbors and from the contaminated or ailing doctor or nurse is an additional safeguard. Intravenous cutdowns, weighings, spinal taps and other procedures are all possible within its protective shell."[1]

For absolute isolation, fresh, pathogen-free, circulating outside air is made available only by the ISOLETTE. When nursery air must be used, addition of the new MICRO-FILTER to the ISOLETTE incubator provides pathogen-filtered air by removing all air-borne contaminants down to 0.5 micron in size. Moreover, ". . . a humidity of 80 to 90 percent can be obtained only in incubators with forced ventilation (e. g., the ISOLETTE)."[2]

For additional information about the ISOLETTE, write to AIR-SHIELDS, INC., Hatboro, Pa. or phone us collect from any point in the U.S.A. (OSborne 5-5200).

1. Lynn, H.B.: Postgrad. Med., **22**:429, 1957.
2. Dancis, J.: Postgrad. Med., **22**:194, 1957.

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Research and engineering to serve medicine throughout the world.

Washington Bureau Reports

by Walter N. Clissold

FEDERAL EMPLOYES HEALTH INSURANCE is now law. It's voluntary, but estimates are that 90 percent will participate. Employes will be offered choice of four different plans — a high benefit, higher cost and a lower benefit, lower cost plan by the "Blues" and by the insurance firms. The government will pay half the cost of the cheapest plan. Look for legislation next year which will provide this insurance to retired federal workers with at least 12 years service. The proposal didn't even reach the floor of either House this year, but seems certain to go the route next year. Would cover some 260,000 retirees, disabled federal employes, their spouses and children at an estimated cost to the government of between $15 and 22 million yearly.

DOCTORS AND OTHER PROFESSIONAL MEN now find the way open to enjoy the tax advantages previously available to employes of firms with pension and profit-sharing plans. Angle is that Treasury Dept. will now recognize an association of professionals. The association, providing centralized management and having an indefinite life, and taxable as a corporation for federal income tax purposes, would get around many state laws which bar corporations from practicing medicine, etc. As a result, important tax savings would be available to the members.

HEALTH AND HOSPITALS programs ranked 7th in government functions in the fiscal year which ended in 1958. Required 4.1 percent of the nation's total tax bite of $98.3 billions for federal, state and local governments. Number one function, of course, is national defense and international relations which got 39.8 percent; second, education, 14.4 percent.

IMPORTANCE OF BREAD in hospital and other diet regimes was pointed up in testimony at a hearing held on Federal Trade Commission charges alleging false advertising by a leading diet bread franchiser. Bread's proponent was Dr. Herbert Pollock of New York City. The requirement of bread in a balanced diet is also stressed in the Agriculture Yearbook for 1959, released end of September. Entitled "Food" it is a rich source of information on nutrients and their functions. The 736-page book is available at $2.25 from the Supt. of Documents, GPO, Washington 25, D. C.

FOOD AND DRUG appropriations for the current fiscal year are 26.4 percent over last year's figure. The increased funds are expected to be used to provide additional laboratory and clinical studies on new drugs and to expedite handling of safety clearances; also to step-up the number of inspections of drug factories; and increased activity in connection with the new Food Additives amendment.

TAX RULING: Internal Revenue says federal income tax will not be levied against amount of salary or wages withheld by employer for meals and lodging furnished on the business premises for the employer's convenience, where employes are required to accept such lodging in order to properly perform their duties. Retroactive to 1954. Refer to Revenue Ruling 59-307.

CRIPPLED CHILDREN — about 313,000 handicapped benefited from federal-state programs in 1957, vs 110,000 in 1937 when such care began. Average hospital stay per child has dropped from 43.6 days to 24.4 since 1937, according to Mrs. Katherine Oettinger, chief of HEW's Children's Bureau. But average hospital cost per child rose almost 200 percent — from $8.95 in 1945 to $26.81 in 1957.

$2 MILLION LOAN to University of North Carolina for construction which includes addition to nursing school dormitory to house 83 student nurses has been approved by the Housing & Home Finance Agency.

NEARLY $175 MILLION were paid out for 9,377 research grants and construction of research facilities in non-federal institutions in the last fiscal year. National Institutes of Health reports almost $30 million went to cancer studies, while heart research took another $25 million. Grants went to organizations in 33 foreign countries as well as in the U. S. and territories.

FEDERAL RADIATION COUNCIL activities are being stepped up with increased funds going to both Public Health Service and Food and Drug for this work. HEW Secretary Flemming heads the Council which is charged with numerous responsibilities aimed at protecting public health from all sources of radiation, including medical use of isotopes and X-rays.

ARMY'S SURGEON GENERAL, Leonard D. Heaton, was raised in rank to Lt. General before Congress adjourned. Some see precedence in this move for upping to 3-star rank of all SGs' of the armed services. Note is taken of fact that each is responsible for medical and hospital care of nearly a million men, plus dependents and retirees.

PEOPLE: *Dr. John R. McGibony* has left his post as head of the course in h. a. at Pittsburgh U. to again join PHS with assignment to the State Dept. as consultant to India's new medical program . . . . . *Dr. George M. Lyon,* manager of VA's Huntington, W. Va., hospital, received the agency's Exceptional Service Award for pioneering in atomic medicine . . . . . *Lt. Col. Louis E. Mudgett,* MSC, named new executive officer of Army SG's Professional Div., succeeding *Lt. Col. W. L. Austin,* transferred to Frankfurt, Germany . . . . . *Dr. Robert D. Wright,* Charlottesville, Va., named assistant director for Health & Medical Activities in HEW's Office of Vocational Rehabilitation. *Dr. Frank H. Krusen,* on leave from Mayo Clinic has been serving temporarily as special assistant of HMA, OVR . . . . *Dr. Stanton Garfield* (grandson of President Garfield) retired from PHS's International Health Div. as Fellowship Program Director & Training Officer . . . . . *Dr. E. M. K. Geiling* is FDA's new medical officer in charge of its Pharmacodynamics Branch, Div. of Pharmacology . . . . . interested visitor to the National Institutes of Health was Dr. A. M. Markov, chief of the Kremlin's Medical Service, who accompanied Premier Khrushchev on his trip to the U. S.

Please turn to page 116

Lehn & Fink
PROFESSIONAL DIVISION

staph newsletter

THIRD OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTION

EARLY in October we had the privilege of seeing a dramatic scientific exhibit at the American College of Surgeons' meeting in Atlantic City. Under the title "How to Stamp out Staph in the Operating Room", Dr. Ralph Adams presents the results of the complete system used in the 50-bed Wolfeboro, New Hampshire, hospital of which he is Chief of Surgery. Having kept meticulous records through over 800 consecutive cases, Dr. Adams is able to show that they did "stamp out staph" and that the low cost of doing so far outweighs the costly hazards of not doing so. Only two infections occurred.

Emphasis is on a completely integrated plan including: cleaning and disinfecting all surfaces and areas vigorously with a combined disinfectant-detergent (Tergisyl®); linen and blanket disinfection with Amphyl®; strict policing of O.R. entry and the preparation of hospital personnel for entry; isolation of patient's skin by impervious plastic skin drapes; and proper masking and attire. Watch for this exhibit at other professional meetings. Both the system and the savings in cost are immensely interesting.

There seems to be an increasing number of reports in the medical journals on the dangers of the cord in the newborn as a portal of entry for infections. One report seems particularly significant. After a 2½ year study at Brooke Army Hospital, it was found that the staph infection rate increased from 5% on the day of birth to 65% on 1-day-old infants and 85% on 2-day-old infants. (J. Ped. 53:538, Nov., 1958)

After the first Staph Newsletter appeared, we were deluged with requests for Dr. Otto H. Ravenholt's article on eliminating staph in blankets by using Amphyl® routinely in the laundry procedure. Dr. Ravenholt's comparative study confirms 98% reduction in colony count on blankets in use. Many hospitals who wrote us were concerned about damaging wool blankets while killing staph and other organisms. Best evidence that Amphyl disinfection will not damage blankets is that a Seattle sanatorium has wool blankets in service now which were bought ten years ago and have been Amphyl-washed-and-disinfected at least once a week without injury. We now have a new supply of Dr. Ravenholt's article which cites this and, also, a new instruction card on disinfection of blankets, linens, and diapers. Both are available in quantities for discussion or teaching, along with necessary samples. Please write for them.

Staph kills Caruso. Yes, Enrico Caruso. Physicians in Naples, where he died 38 years ago, described the cause of death simply as an abscessed kidney which ruptured and produced peritonitis. Looked at with today's increasing knowledge of the ravages of staph, "it seems likely that he had pneumonia, empyema, satellite abscesses on the fascia and muscles of the left side of the chest, a subphrenic abscess, possibly a perirenal abscess, and terminally, general peritonitis". You'll find the complete report by Dr. Richard W. Prichard in the Surgeon's Library section of the July, 1959, issue of Surgery, Gynecology & Obstetrics.

Have you made plans yet for showing the new motion picture produced by the Communicable Disease Center of the U. S. Public Health Service, "Prevention and Control of Staphylococcal Disease"? It points up many danger spots in the hospital and gives practical, pertinent suggestions for overall control. The demand for the copies of this film which we procured especially for your use is increasing fast, so let me know soon when we can schedule an early showing for you.

Another film you won't want to miss is "Hospital Sepsis: A Communicable Disease", sponsored jointly by the AMA, ACS, and AHA on an industry grant with the technical advice of Dr. Carl W. Walter. Documentary scenes were made under actual hospital conditions as a real staph patient contaminates her surroundings. For environmental control, generous use of disinfectant-detergent is demonstrated. We do not have this film, but we do have Tergisyl® disinfectant-detergent which fits the recommendation made by Dr. Walter at a Massachusetts Medical Society meeting earlier this year—that a synthetic phenolic is the product of choice for operating room floor care. If you would like Tergisyl samples and literature, please ask for them.

If you don't already have it, please make a note of our new address shown below. Early in October the Professional Division of Lehn & Fink moved into new, larger executive offices in Toledo. When you want to know more about how Amphyl®, Lysol®, and O-syl® disinfectants, and Tergisyl® disinfectant-detergent can help you control any sort of cross infection—please write us. We realize this is only one part of the complete control program, but an important one. As always, our research laboratories and technical advisors are ready to help and I, personally, would like very much to hear from you.

Felix M. Bronneck

Felix M. Bronneck, Manager
Professional Division

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Guest Editorial

Hospital Planning Council For Metropolitan Chicago, Inc.

by Karl S. Klicka, M.D.

Executive Director
Hospital Planning Council
for Metropolitan Chicago, Inc.
Chicago, Illinois

The Cook County Health Survey, completed in 1947, contained a recommendation that a permanent authoritative group be established for the planning and coordination of hospital facilities and services and for reviewing and approving proposals for capital expenditures for all future construction in the interest of organized care of the sick.

Despite this early recognition of the need for centralized hospital planning for this large metropolitan community, it was not until May, 1955 that a meeting was convened to discuss the establishment of an organization to carry out this function. This meeting was well attended by representatives of health agencies as a demonstration of the widespread acceptance on the part of knowledgeable people that such a body was necessary.

Subsequent meetings were held for continued discussion, and two and one half years later the Hospital Planning Council for Metropolitan Chicago was incorporated as a nonprofit corporation on December 18, 1957. The first meeting of the Board of Directors was held on September 15, 1958 and on the same day the office was opened for business. Thus 11 years elapsed between the Chicago-Cook County Health Survey Report recommendation and the actual establishment of an organization to carry out its recommendation.

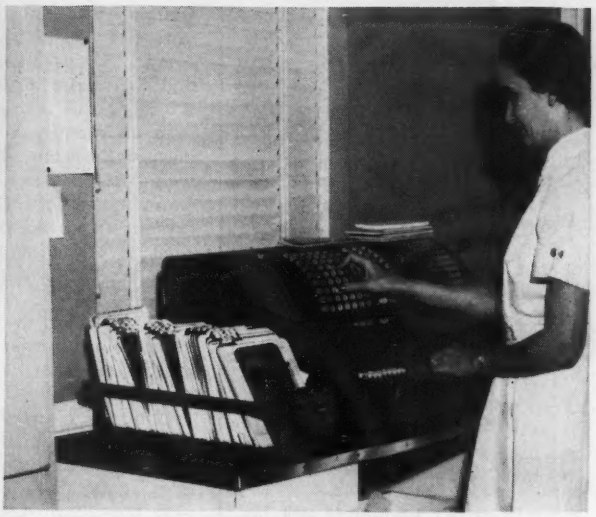
This brief history illustrates the point that an organization of this type whose creation requires the cooperative action of many voluntary agencies is not easily accomplished. It should be of some consolation to communities that are having difficulty establishing a similar office. Furthermore, the Chicago experience should encourage others not to cease trying even though years have been involved in what might appear to be nonproductive meetings.

A very important fact evolves from this. During the period that the Hospital Planning Council was under discussion, the need for such an organization became increasingly clear to all those having an interest in health matters. As a result, the executive director is not concerned that the hospitals and health agencies may not cooperate with his office. Instead, he and his staff are hoping that they can meet the pent-up needs of the hospital community and keep abreast of the requests for information and assistance that are received almost daily.

Perhaps the greatest reason for the delay in organizing the Planning Council was the inability to create a group that would be completely objective and which would not be criticized for having any biased or prejudiced opinions. The budget was also a problem, for no existing health agency could add the expense of such a function when they were constantly pressed for funds to carry out the activities to which they were already committed.

This dilemma was solved when the Chicago Association for Commerce and Industry assumed the necessary leadership. A study by its Health-In-Industry Committee under the Chairmanship of Mr. Lemuel B. Hunter, assistant to the president of Inland Steel Company, led to a working plan for this new agency. The Hospital Planning

THE BIRMINGHAM BAPTIST HOSPITAL provides ultra-modern hospital facilities for its many patients.



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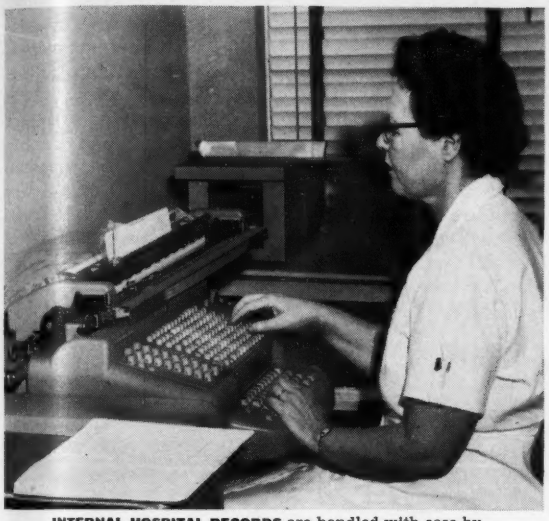

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"Our National System pays for itself every 18 months through savings realized in operating costs over our previous system, a return of 67% of our equipment investment each year."

P. H. Taylor

Comptroller
Birmingham Baptist Hospital

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★ New, patented 'Sexauer' SELF-LOCK screws have imbedded expanding NYLON PLUG. They lock at required depth AUTOMATICALLY, hold washers firmly! Made of MONEL, they are rustproof, non-corroding. Heads can't twist off. Screw slots can't distort.

★ NEW, improved 'Sexauer' EASY-TITE faucet washers are made of super-tough, pliable du Pont compound (not rubber or fibre). Reinforced, like a tire, with a vulcanized layer of Fiberglas, they resist distortion and splitting from shut-off grind and squeeze.

★ Faucet leaks repaired with 'Sexauer' EASY-TITE washers and SELF-LOCK screws outlast ordinary repairs "6-to-1"!

HIDDEN COSTS OF FAUCET LEAKS!

Hackensack, N.J. Water Co. and American Gas Association figures prove stopping just ONE PIN-HOLE SIZE (1/32") LEAK saves you 8,000 gal. water quarterly. A HOT WATER FAUCET LEAK repair saves you over $7.58 QUARTERLY in fuel and water bills. Fewer leaks also produce important savings on MATERIALS, LABOR and COSTLY FIXTURE REPLACEMENTS!

A 'Sexauer' Technician will make available our NEW Catalog, Edition "J", listing our entire line of over 3,000 TRIPLE-WEAR plumbing repair parts and tools. He will survey your fixtures, determine the repair parts needed and establish an efficient stock arrangement and control to prevent costly overstocking or shortages. You get this service without obligation. *Act now!*

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WORLD'S LEADING SPECIALISTS IN PLUMBING AND HEATING REPAIR PARTS

Council was subsequently formed with a board of directors including many of Chicago's key philanthropic and industrial figures. Edward L. Ryerson, the retired Board Chairman of Inland Steel Company, was elected President. Funds to underwrite the operation of the Planning Council were obtained by contributions from industry and foundations. A continuation of this source of support is anticipated for the future.

Industry has, therefore, taken the leadership in this important community program. It has done so out of a realization that hospitals are looking to industry for an increasing percentage of their financial requirements to expand and renovate present facilities and to construct new ones. Industry recognizes that it is going to pay a large portion of the bill, so it must know that the dollars that are to be spent are spent wisely and in a way that will create the best possible hospital system, quality as well as quantity wise.

The objectives and purposes of the Council are these:

measure future needs for hospital care in the metropolitan area of Chicago;

create over-all plans for the efficient and economical development of a hospital care system that will most adequately meet the area's needs;

measure financial requirements for providing adequate hospital care in relation to estimated resources available from the community;

review hospital proposals for major capital expenditures and make recommendations in light of over-all plans for the metropolitan area;

help coordinate hospital services within the metropolitan area and help relate hospital facilities to the community's health and welfare agencies;

promote joint interests of hospitals and the medical professions on a community wide basis;

inform the public of the financial needs of hospitals and increase public knowledge and understanding of hospital services in the community.

The program is both short range and long range. Short range to answer questions asked now by hospitals in the process of developing plans for their immediate future. Long range to assist hospitals in building in a way that will best meet the ultimate health facility needs of this great metropolitan area. The long range program will develop among three principle lines:

estimating the future growth of the Chicago metropolitan area;

determining the implications of this growth for future hospital care requirements;

analyzing means for coordinating the development of the area's hospital system so that it will meet future needs most effectively and efficiently.

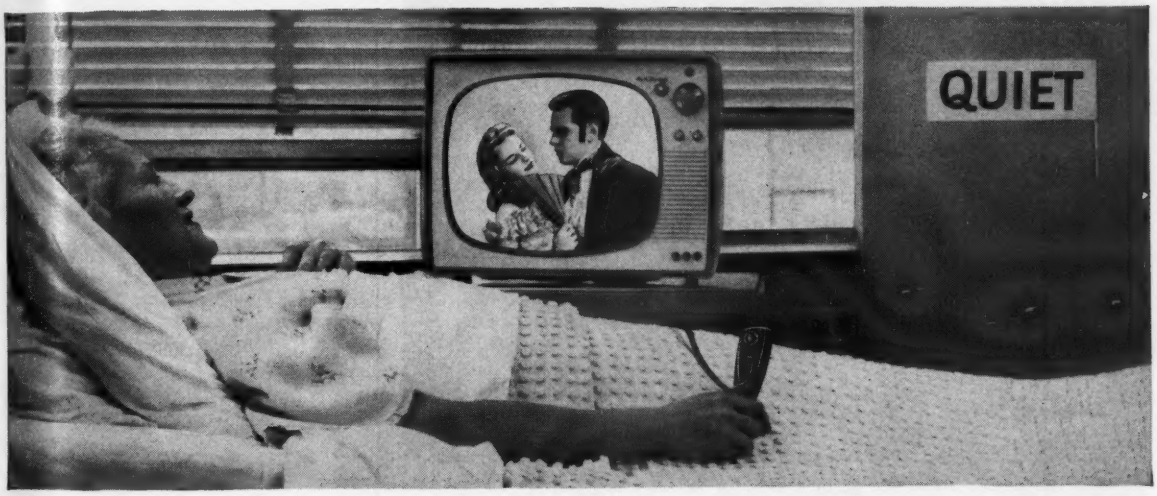
The spirit of cooperation is present with us today. It is the responsibility of the Council, therefore, to operate today and in the future in a manner that will maintain this favorable climate. God willing, we will render the best service we can to our community and hope it is good enough. ■

Let's Play It Safe

WRONG: Handling contaminated sponges with bare hands and running the risk of becoming infected.

RIGHT: Wearing rubber gloves to protect against infection.

This RCA Victor TV tunes by remote control—



and this remote control TV has a pillow speaker!

Read how these RCA Victor TV sets solve all 9 hospital TV problems

(1) Tuning TV from a bed was a problem. But these RCA Victor Newsmakers, *The Rosedale* (top), *The Caldwell* (below) tune by remote control. Patients don't have to leave their beds—hospital staff doesn't have to waste time tuning for them. **(2)** TV noise was a problem. But these TV sets can't be played too loud. A volume limiter is built in —adjustable only by a TV serviceman. And *The Caldwell* has an optional pillow speaker for personal listening. **(3)** Moving TV was a problem. But these RCA Victor Tote-ables are shaped for easy carrying. **(4)** Where to put TV was a problem. RCA Victor's compact size and very-thin styling lets you put TV on a bed table or dresser. **(5)** The TV finish was a problem. These sets have a durable, lustrous cabinet that is even liquid- and burn-resistant. Easy to clean, too! **(6)** Amateur "TV Fixers" were a problem. Tamperproof TV backs defy tinkering with makeshift tools. **(7)** TV performance from a small set was a problem. These RCA Victors are less than 15" deep—yet they have the picture and sound of a big set. A full 156 square inches of brilliant picture. 17" tube (overall diagonal). **(8)** Good, clear reception was a problem. But an RCA "Antennaplex" master antenna delivers the finest reception possible even in fringe areas. If the "Antennaplex" system is not used, RCA Victor hospital TV sets have a built-in telescoping antenna to deliver a fine picture. **(9)** Interference was a problem. But every RCA Victor TV Newsmaker is double-shielded to reduce interference to a minimum.

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Tests show that routine use of Hexa-Germ degerms skin to a degree approaching sterility. It has also been proved effective in preventing staphylococcal skin infections in the newborn nursery. And the emollients in Hexa-Germ replace the natural oils in the skin lost through prolonged cleansing. A special preservative in Hexa-Germ helps prevent contamination that can result from handling, from the shipping containers to the dispenser jars, with a wide margin of safety. See our representative, the Man Behind the Huntington Drum, for full details. • Huntington Laboratories, Huntington, Indiana, Philadelphia 35, In Canada: Toronto 2.

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Hospital Calendar

November

4- 7 . . **American Association of Blood Banks,** Edgewater Beach Hotel, Chicago, Ill.

5- 6 . . **Oklahoma Hospital Association,** Mayo Hotel, Tulsa, Oklahoma.

9-14 . . **American Surgical Trade Association,** Chase Park Plaza Hotel, St. Louis, Missouri.

12-13 . . **Kansas Hospital Association,** Town House Hotel, Kansas City, Kansas.

12-14 . . **Virginia Hospital Association,** Hotel Chamberlin, Old Point Comfort, Virginia.

December

3- 4 . . **Hospital Association of Hawaii,** Hawaiian Village, Honolulu, Hawaii.

4 . . **Illinois Hospital Association,** Abraham Lincoln Hotel, Springfield, Illinois.

9-11 . . **National Association of Central Service Personnel,** Belmont Plaza Hotel, New York, New York.

1960

January

21-22 . . **Alabama Hospital Association,** Dinkler-Tutwiler Hotel, Birmingham, Alabama.

February

16-18 . . **National Association of Methodist Hospitals and Homes,** Deshler-Hilton Hotel, Columbus, Ohio.

16-18 . . **American Protestant Hospital Association,** Deshler-Hilton Hotel, Columbus, Ohio.

March

24-26 . . **Louisiana Hospital Association,** Bellemont Motor Hotel, Baton Rouge, Louisiana.

For more information, use yellow postcard inside back cover.

What every O.R. and Central Supply Nurse should know about A·S·R SteriSharps blades

Q. *What are SteriSharps?*

A. They are sterile-packed surgical blades made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments they will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharps blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharps packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharps packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharps blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharps blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharps does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HM, 380 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada—A·S·R HOSPITAL DIVISION, 2055 DESJARDINS AVENUE, MONTREAL, CANADA

Literature and samples for your evaluation available upon request. If you have further questions—ask us.

A·S·R **SteriSharps . . . the first sterile, stainless-steel surgical blade**

PRECISION A·S·R PRODUCTS

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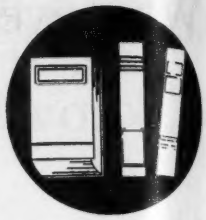
Books



The Family Medical Encyclopedia

by Justus J. Schifferes, Ph.D. Little, Brown and Company, pp. 617. $4.95.

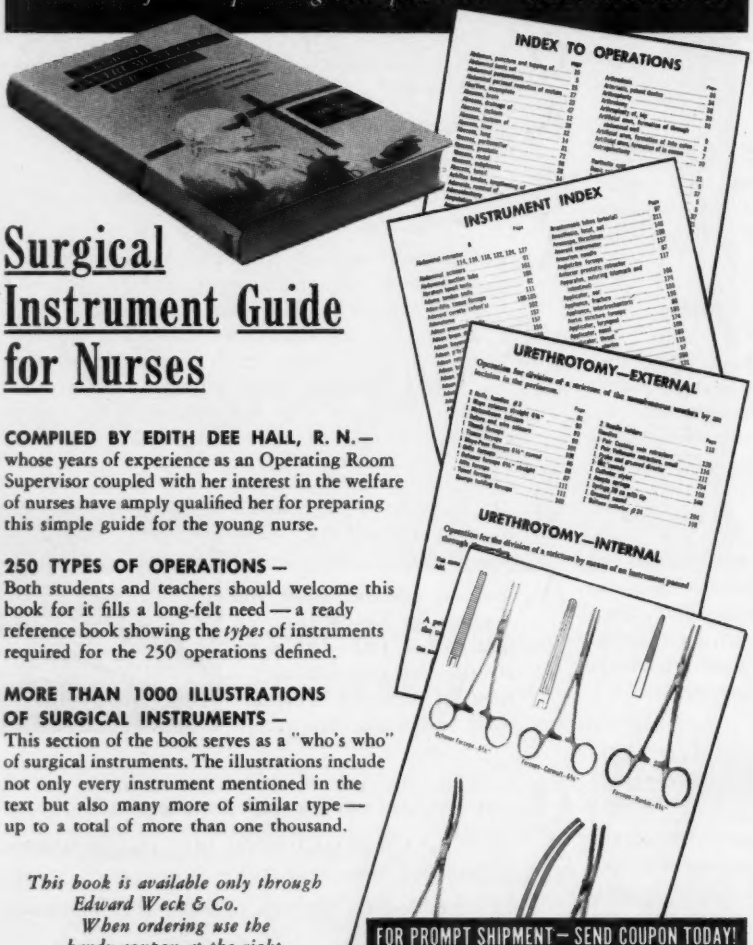
■ THIS COMPACT, well thought out "encyclopedia" has a variety of useful information compressed into its mere 617 pages. The preface successfully guides the reader into the proper usage of the book. It explains how it is organized, what information one can expect to find in it, and how to read the book to the best advantage. The subjects are arranged alphabetically but a cross-index is supplied to enable the reader to find quickly the information he desires.

Written in simple terms, the contents of the manual can be understood easily by the average layman. In this respect it is different from other medical books which often confuse rather than instruct.

The book has many points to recommend it. Among other subjects, it contains a fairly comprehensive discussion of cancer, arthritis, heart disease and other leading causes of death; a listing of medical and allied health associations that will furnish specialized information on request; an index of initials used in doctors' prescriptions; a list of medical terms found in medical records and an emergency first aid index.

This book is meant to be a family reference book but it may also prove useful to the nurse aide, the hospital volunteer or the trustee in helping them to understand medical and hospital matters. C.U.L. ■

"This orderly book will save many an hour and many a headache for the operating room personnel" — HOSPITAL TOPICS



Surgical Instrument Guide for Nurses

COMPILED BY EDITH DEE HALL, R. N. — whose years of experience as an Operating Room Supervisor coupled with her interest in the welfare of nurses have amply qualified her for preparing this simple guide for the young nurse.

250 TYPES OF OPERATIONS — Both students and teachers should welcome this book for it fills a long-felt need — a ready reference book showing the *types* of instruments required for the 250 operations defined.

MORE THAN 1000 ILLUSTRATIONS OF SURGICAL INSTRUMENTS — This section of the book serves as a "who's who" of surgical instruments. The illustrations include not only every instrument mentioned in the text but also many more of similar type — up to a total of more than one thousand.

This book is available only through Edward Weck & Co. When ordering use the handy coupon at the right.

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HM-11-59

Hospital Diets

Published by the Department of the Army and the Air Force, December 1957. pp. 119, $.40.

■ A concise document covering almost every aspect of therapeutic dietetics in hospitals has recently been published by the armed forces. Useful not only in the dietary department but might also be helpful to the medical record department and to the nursing department in establishing routine and interpreting abbrevations. Highly recommended. C.U.L. ■

Games and Fun for Parties

by Sylvia K. Mager. Arco Publishing Co., Inc., New York 17, 1956. pp. 44. $2.00

■ AN ILLUSTRATED GUIDE designed for adults, as well as children, to make a complete social success of any party with tested solutions to the problem of keeping mature people entertained for hours. The book includes chapters on invitations, food, decor, and a repertoire of 19 different types of parties. Good addition to your school library. HVE ■

(*Advertisement*)

Comparing Notes with Hospital Pharmacists

Highlights of my visits to hospital pharmacies across the country

by Alfred A. Mannino
EXECUTIVE DIRECTOR, HOSPITAL DEPT.
McKESSON & ROBBINS, INC.

I HAVE just returned from another extensive trip throughout the United States, and I find that the importance of the Hospital Pharmacy is growing each day. In fact, it was quite obvious to me that the role of the Pharmacist cannot be underestimated in any hospital—large or small.

In Tennessee—Among the many questions of common interest which I encountered was: "Should Central Supply be combined with the Pharmacy?"

I cannot answer this completely in a few words, but I know that this combination has been working well at many hospitals. For example, Grover Bowles, Director of Pharmacy Service at the Baptist Hospital in Memphis, Tennessee, has recently taken over the Central Supply operation with considerable success. I plan to elaborate on this subject in a future article.

In California—In one of the hospitals we visited in San Francisco we met a Pharmacist who had just received a prescription for a foreign-made product. As you know, many of our present-day internes have been schooled in foreign countries. This creates the problem of where to obtain these foreign drugs, and where to find information about them. Bob Gossitt of our San Francisco Division has most of the answers. Bob has been well trained in the duties of "Rex" McKay®, and is usually able to provide information even on foreign prescriptions. ("Rex" McKay is the professional name used by the expert pharmaceutical consultant in each of McKesson's 84 Drug Divisions.)

In Indiana—On my way through Indiana I spent a day at Evansville as the guest of the Indiana Catholic Hospital Association. Sister Elizabeth, Administrator of St. Mary's Hospital, was my hostess on a tour of this beautiful, modern hospital. The Pharmacy had been well-planned under the direction of Mr. Wiley. As I commented on the other Pharmacies I had seen, Sister Elizabeth asked me why I traveled so much. The answer is that such visits give me the best opportunity to learn about Hospital Pharmacy and other hospital problems.

In Texas—Bob Lantos, Director of Pharmacy Service, University of Texas Medical Branch Hospital, cordially showed me all the phases of his Pharmacy operation. Bob has several problems common to City, County, State and Federal Installations. Because of the bid procedures used in this type of institution, there is a longer lapse of time between requisitioning and receiving merchandise. This means that stocks must be anticipated, and inventory standards are difficult to maintain. Nick Wollard, Sales Manager of McKesson's Houston Division, has often been able to help Bob when he needed items on an emergency basis.

In Massachusetts—Another type of operation that requires careful inventory control and fast deliveries is the Government Out-Patient Clinic. In one such clinic in Boston the Chief Pharmacist and his staff handle a great many prescriptions each day. Their efficient organization provides for adequate stocks and nearby sources of supply to expedite prescriptions.

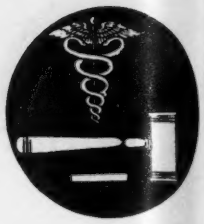
In Minnesota—The American Society of Hospital Pharmacists has contributed greatly to the recent progress of Hospital Pharmacies. I have been privileged to be invited to speak before about 25 local chapters of the A.S.H.P. I have found that in many areas, such as Minneapolis, the local chapter invites detail men and salesmen to participate in their meetings. I think this is very helpful to both the Pharmacists and the salesmen, and will certainly work to the advantage of the patient.

In Ohio—On a subsequent jaunt, I was lucky to be able to get to Cincinnati for the meeting there of the A.ph.A. and A.S.H.P. Pardon me if I get carried away, but this was really inspiring. It was the best attended, most progressive, most interesting meeting of pharmacists ever held—a dramatic demonstration of the advances we have made.

Wherever I went throughout the country, noting the great recent strides of Hospital Pharmacies and the growing importance of Pharmacists, I found Pharmacists who were enthusiastic and grateful for the help they get from McKesson's Hospital Service Departments. In fact, 60% of the nation's hospitals depend on McKesson in the efficient management of their Pharmacies. A McKesson representative will be glad to discuss your problems with you. Write me for the name of your nearby McKesson Hospital Service Department. Address: A. A. Mannino, McKesson & Robbins, 155 East 44th Street, New York 17, N. Y.

For more information, use yellow postcard inside back cover.

Hospitals and the Law



Emanuel Hayt, LL.B.

Doctrine of Res Ipsa Loquitur Applies in Malpractice Action If Occurrence Ordinarily Bespeaks Negligence

■ IN AN ACTION FOR DAMAGES plaintiff sued defendant physician for injuries occurring when defendant gave him a shot of penicillin as treatment for a cold. After the shot in the right buttock plaintiff instantly became numb from his thigh to his foot, later being seized with violent shaking. Plaintiff's buttock became swollen greatly, and he was hospitalized for two days and given treatment for three months. His recovery has not been complete, the injury being diagnosed as damage to the sciatic nerve. After plaintiff presented his evidence, defendant's motion for dismissal was granted and plaintiff's motion to recall defendant and a medical witness was denied because plaintiff failed to establish by expert testimony of those qualified by their own skill and knowledge in the same profession the requisite degree of professional skill demanded of a physician and to establish by such testimony that defendant had not exercised that degree of knowledge and skill which usually pertains to other members of his profession.

Plaintiff appealed, claiming that he had established a case falling within the doctrine of res ipsa loquitur. This court held that while the testimony of experts concerning the standard in the profession and a deviation therefrom is not always necessary for the application of res ipsa loquitur, in this case it was because one cannot say that the occurrence here ordinarily bespeaks negligence. The witnesses which plaintiff wished to recall would not have supplied testimony as to the standard of care and the deviation therefrom, and, therefore, the denial of plaintiff's motion to reopen could not have affected the final result.

The judgment of dismissal was affirmed.

(Toy v. Rickert, 146 A. 2d 510—N.J.)

Mental Patient Should Have Had Close Supervision To Prevent Suicide

■ THE DECEDENT was committed to the Middletown State Hospital in May of 1952 because of her mental condition and suicidal tendencies and remained there almost continuously until July 9th, 1953 when she took her life by hanging.

During the time of her confinement she had received a considerable number of what is commonly known as "electric shock treatments," but there was no evidence that she had recovered from the suicidal inclinations. She was kept in an infirmary for such type of patients until December 26th, when she was transferred to what has been referred to as Ward 12 "because of the necessity of creating a vacancy in 93" (Infirmary).

The testimony showed that the infirmary was so arranged that it was easier to keep the patients under surveillance and there were more personnel to supervise and attend them.

The claimant offered medical proof to show that decedent's physical health was reasonably preserved and that the treatment given her for her mental condition was a well established and recognized procedure.

The doctor further testified that she was suffering from "involutional psychotic reaction, depressive and paranoid type" of mental illness and that it was necessary to provide patient with such supervision "which would safeguard the patient against acting upon an impulse to end the patient's life." The claimant offered further testimony from the members of decedent's family and the testimony [examination before trial] of doctors who had been associated with the institution at the time of the unfortunate occurrence. One of the doctors testified that where a patient has marked suicidal tendencies whenever possible they are kept in the infirmary rather than Ward 12.

From the testimony present here we are satisfied that the claimant made out a prima facie case of negligence against the State and under the circumstances the claim should not have been dismissed.

Judgment was reversed, on the law and the facts, and a new trial granted.

(Herold v. State of New York, 9 CCH Neg. Cases 2d 986—N.Y.)

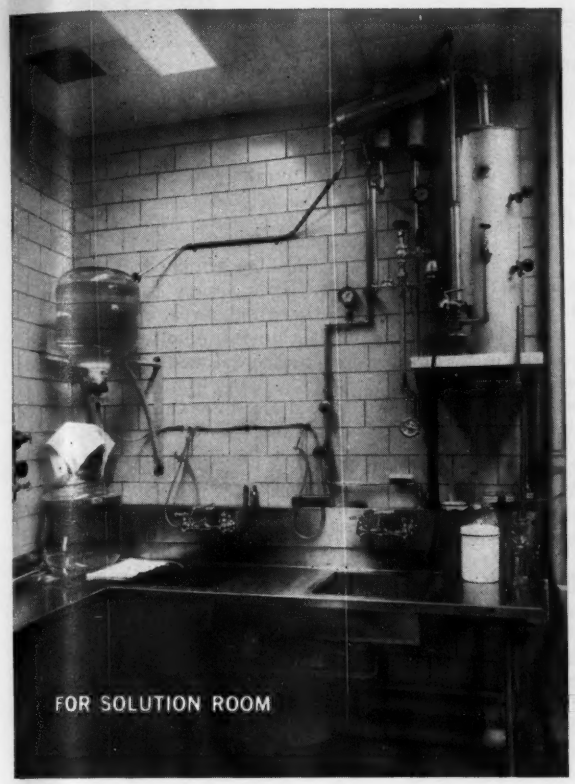
Public Hospitals In Georgia Liable For Injury To Paying Patients Limited To Income From Paying Patients

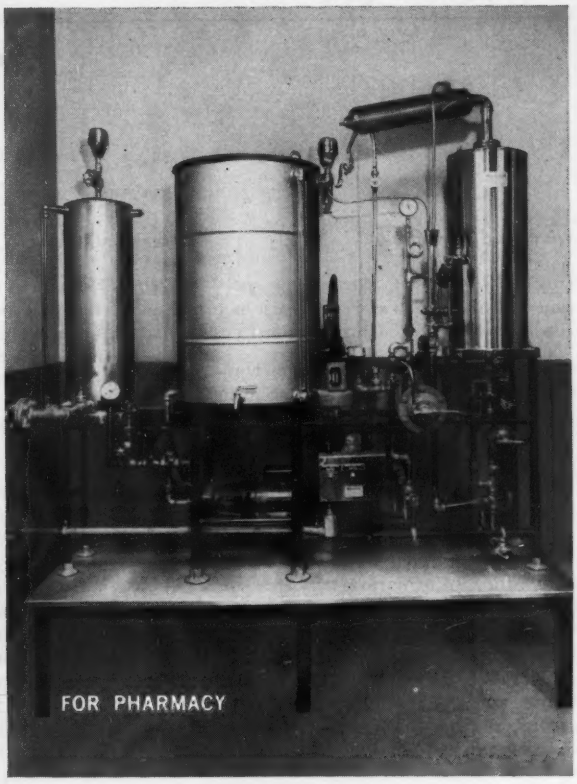
■ THE PETITION seeking to recover damages including medical expenses, hospital expenses, loss of services of and loss of consortium of plaintiff's wife, a paying patient, arising out of the alleged negligence of the defendant, through its agents and servants, in failing to place plaintiff's wife in the security ward, as directed by her physician, while she was in a mentally disturbed condition of which defendant had actual notice or which it should have discovered through the exercise of ordinary care, in failing to keep constant and continuous watch and care over plaintiff's wife while in said condition, in failing to administer certain prescribed medicines to sedate and tranquilize said wife and in allowing plaintiff's wife while in said mentally disturbed condition to wander some 50 feet down a hallway, lock herself in a bathroom, climb into the window thereof and fall from said window three stories to the ground, sets forth a cause of action. This is true notwithstanding a general judgment is prayed for and the recovery is not by the petition limited to the income derived from pay patients.

A hospital authority created under Chapter 99-15 of the Georgia Code is subject to a suit for damages for personal injuries to one of its patients resulting from the negligence of its agents, servants or employees.

(Hospital Authority of the City of Marietta v. Misfeldt, 9 CCH Neg. Cases 2d 800 — Ga.) ■

AT NEW ENGLAND BAPTIST HOSPITAL


FOR SOLUTION ROOM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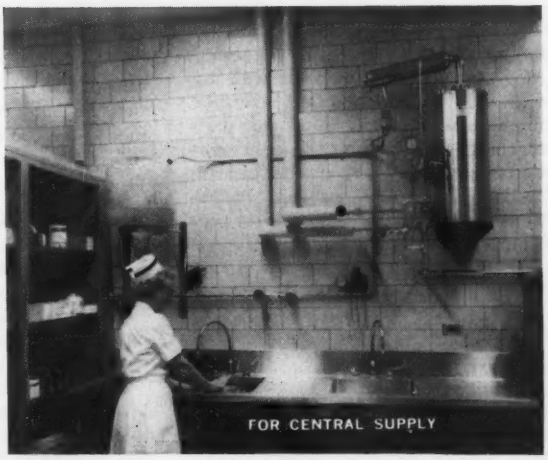
Whatever your hospital need . . . you will find a Barnstead Still to fill your exact needs . . . over 200 models and sizes to choose from . . . with such features as full automatic controls to insure a constantly available supply of freshly distilled water . . . Ventgard attachment which prevents air-born contamination from entering the storage tank . . . and tin-lined piping to protect distilled water from source to point of use.

You can place your trust in Barnstead's 80 years of specialized experience in Water Still design. Write for Hospital Catalog "H" . . . describes Stills especially designed for hospital use.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Medical Records

Adaline C. Hayden, C.R.L.

Privileged Information

***QUESTION*: What portion or portions of the medical record are not considered privileged information?**

ANSWER: Information not considered privileged and available to any individual on request is the following:

complete name of patient;

address of patient (as given at time of admission);

verification of his hospitalization;

admission and discharge dates.

Any other information may not be disclosed without proper authorization to the institution. Even with authorization caution should be exercised in disclosure of names as house officers and personnel are agents of the institution which is liable for their acts.

Outpatient Medical Records

***QUESTION*: Is there any specific organizational pattern for outpatient medical records?**

ANSWER: No specific kind of organizational pattern is suggested. Medical records should be well integrated with inpatient service. Such service seems to provide better care and assures the continuation of care. If there are 30 percent readmissions with interval outpatient visits, the Unit System is recommended.

An X-Ray Index

***QUESTION*: What is the best method for setting up an x-ray index?**

ANSWER: I find the most effective and simple way to index x-ray diagnoses is alphabetically by body areas. This may be done by following the topographic section of the "Standard Nomenclature of Diseases and Operations." The card may be designed to fit the needs but the index must identify the proper films for study and review.

Accident Cases

***QUESTION*: I am in a private hospital and in the past two months we have had three accident cases brought in for treatment. In this type of hospital is it necessary to maintain a medical record? We have a record of these cases being treated in the business office.**

ANSWER: My answer is definitely Yes. Adequate medical records on every patient must be kept. If a regular emergency service is maintained by the institution, there are other factors to be considered which are administrative and should be taken care of by administration. Administrative factors are not your problem but let it be known that you want a medical record on every patient seen in the hospital. If you do not have emergency record sheets in use, procure samples and present them to the medical record committee and have a particular sheet adopted for use for all emergency cases.

Rules for Preparing Graphs

***QUESTION*: I was recently told by a neighboring record librarian that there were two sets of rules to be used in preparing graphs. Can you give me these rules?**

ANSWER: There are certain rules to be followed in the preparation of any table, these are:

all tables should have brief descriptive titles, misinterpretations may be avoided by use of subtitles or footnotes;

tables should be numbered or identified for reference;

tables should have a notation at the bottom, preferably the lower left hand corner, indicating the source of the data;

all columns and rows should have designations or names;

all lettering sould be horizontal if possible.

The line graphs are those used most frequently by the record librarian. The rules to follow in drawing line graphs are:

the arrangement is from left to right, with the reading of the vertical scale from bottom to top and the horizontal scale from left to right;

the base line should always be zero, however, if this distorts the graph a horizon break may be shown just above the "X" axis;

when quantities are plotted on a chart with the time on the "X" axis, the point of plotting should be in the middle of the line space period if quantities are for the whole period;

when quantities are cumulative for succeeding periods, the quantity should be plotted from the right hand point to the time period;

coordinate lines should be sufficient to permit easy reading but not too numerous to confuse the eyes;

all lettering should be horizontal;

line graphs, like tables, should have titles, identification, and should state source of data.

There are many other types of tables and to acquaint yourself with these and other factors pertaining to elementary statistics, the following references are recommended: "Elements of Statistics" by A. L. Bowley; "Primer of Statistics" by W. P. and E. M. Elderton; "Introduction of Statistical Methods" by H. Secrist; "History of Statistics" by J. Koren; and "Principles of Statistics" by R. E. Chaddock.

Medical Staff Meetings

***QUESTION*: Why are medical staff meetings so important?**

ANSWER: This is not a medical record problem and as medical record librarian you need not be concerned. This is purely administrative but if you are asking just for information, the sole purpose of medical staff meetings is to improve the quality of patient care by means of review and evaluation of the work of the professional staff. ■

HOSPITAL Management November 1959

During a six-month period we had an experience of 390 incidents.

83 percent of the patients apparently were neither harmed nor injured by the incident.

286 were all kinds of falls—less than half of them were falls from bed.

52 percent were fall accidents suffered by patients who were moving about.

Falls A Principal Patient Incident

by Frederick Grubel, LL.D., M.B.A., C.P.A.

Deputy Executive Director
Maimonides Hospital
Brooklyn, New York

■ ONE OF THE OUTSTANDING DIFFERENCES between the human race and the entire animal kingdom is the fact that very illogically and against all laws of physics, man is very delicately balanced on his two feet. He does not use the solid help of his other two extremities to stand or move around the good earth.

All through history, it has been the symbol of human pride and the symbol of human health that we stand upright, we walk upright, and do not have to bow down in order to live. Throughout human history man has observed that deviation from uprightness is indicative of frailty and death. Such frailty may be physical—like sickness and old age; such frailty may be social—like slavery.

In the hospitals we are trying to combat physical frailty, and whoever is concerned with possible accidents of sick people should remember that the fall is the age old symbol of physical frailty. In short, the patient by definition is prone to fall regardless of his physical surroundings. The risk is only aggravated if objective causes add to this innate danger. Such objective causes may be the housekeeper's nightmare: overwaxed or wet floors, defective stairs, tools or furniture obstructing corridors. Faulty patient care equipment, like stretchers and wheelchairs, are causes for which nursing personnel is watching out. Keeping in mind these facts, the probable cause and possible remedies for the fall hazards of patients in hospitals might be determined.

In quite a few instances just the patient's frailty causes him to fall without anybody else's fault, while in many other situations objective causes contribute to the accident. To eliminate this basic frailty is the physician's job; the hospital can only try to eliminate or obviate the objective hazards.

How grave is the danger of fall incidents?

During a six-month period, my institution* gave nearly 108,000 days care to about 5,000 individual patients. We had an experience of 390 incidents. Of these 286 were all kinds of falls — less than half of them were falls from bed; 52 percent were fall accidents suffered by patients who were moving about. In nearly 83 percent of these cases the patients apparently were neither harmed nor injured by the incident. On the other hand, the record of the 104 incidents that were not connected with falls was worse: there only slightly less than 50 percent appeared without consequence.

About 55 percent of the patients who fell were 65 years of age and older. The patients subject to nonfalling incidents showed only 40 percent in the old age group. This seems to confirm that sickness compounded by old age makes the patient definitely more prone to lose his balance.

For the prevention of objective accident causes, the safety rules of industry and household are applicable to the hospital as well. All the good advice against defective floors, ill-lighted walking areas and unguarded obstructions have to be preached to hospital personnel like anybody else. These conditions are dangerous to healthy people as well as to patients, only the more so to the latter because of the innate risk of imbalance.

The most puzzling accident is the fall from bed. Where should a person be safer than when lying in his own bed? Nevertheless, no week passes in any hospital without patients falling out of this apparently safe haven.

Quite some effort and study went into the possible remedies against this danger, which at my own institution represented not quite 40 percent of all fall accidents, a percentage which might be representative of general experience.

The most obvious safeguard seems to be the attachment of side-

*Montefiore Hospital, New York City.

rails. With solid metal rails on both sides of the bed, the patient just should not be able to roll off the bed. Patients who are somewhat disturbed should be deterred by them from getting out. However, the siderail represents to many patients the symbol of restriction of freedom or, even worse, of the special severeness of his ailment. Usually very detailed rules for siderails installation are established by the hospitals, with the full blessings and encouragement of the insurance companies and somewhat reluctant neutrality of the medical staff who are keenly aware of the adverse psychological impact of these rails. Nevertheless, it is accepted by most institutions to guard by siderails, especially at night time, at least the unconscious or heavily sedated patients, unruly patients, as well as the very old and the very young.

It is generally the feeling that if and when a hospital is sued because a patient fell out of bed and hurt himself, the case for the hospital is considerably eased if it can be proven to the court that at the time of the accident siderails were in position. Unfortunately, the statistics I have available do not prove the effectiveness of the siderails. It is quite perplexing to learn that three of the four institutions whose statistics I have available showed that more falls from bed occurred despite siderails in position than in cases where there were no siderails on the bed. Of all falls from bed during a six-month observation period, there were at Montefiore Hospital 53 percent, at Maimonides Hospital 65 perecent and at Muhlenberg Hospital as many as 80 percent, where the patient fell out of bed despite siderails. Only at Mt. Sinai the percentage of falls with siderails in position was below 50 percent (exactly 37 percent).

At Montefiore Hospital, one nursing station with 37 beds was put under very strict automatic siderail rules, while a comparable station with 38 beds continued under the old hospital regulations which require specific physician's orders for the attachment of siderails. Over an observation period of ten weeks, the slightly smaller station with the new strict rules recorded four falls from bed, and the station under the old liberal rule recorded only three such falls. The experiment is being continued and has not shown any different development during recent weeks.

At this point the question arises whether half siderails or full siderails are preferable. It is being pointed out that half rails are better because patients will not climb over the rails but, rather, can hold on to the rails when accidently sliding from bed. This argument does not convince me fully, since according to my own experience quite a few serious accidents could have been avoided if the bed had been equipped with full siderails instead of half rails. However, as the statistics show, the entire question cannot be easily answered.

The puzzle, in my opinion, can only be solved if somebody finds a way of determining how many more patients would have fallen from bed

if there would not have been siderails in position. How this can be done without the gift of clairvoyance is unknown to me. I therefore conclude that just normal common sense much rather than statistical observation prompt hospitals and insurance companies to continue stressing the necessity of strict siderail rules. However, this is not a full solution of the problem.

There are attempts at other remedies. First, the so-called hi-lo bed —if in low position—may at least ease the impact of the fall. If we cannot avoid having the patient fall from bed, let him at least not fall from very high. This solution reminds of a mattress on the floor which was the rule in the sick and poor houses of the Middle Ages. However, modern bed construction does not even give us the comfort of this medieval safety because the lowest of the low of the hi-lo bed is still keeping the bed as high above the floor as mattress, spring and casters combined. In any event, the hi-lo bed does not allow us to dispense with siderails, but it at least represents some progress by having the patient exposed to a shorter fall than from the normal hospital bed.

Second, there is the use of a net spread over the patient's bed and siderails. This net, as it is being used all over the country, has a severe drawback that it actually pins the patient down into a prone position. Unless the patient is completely unconscious, this net must be combined with physical restraints to the patient, quite a desperate device remindful of the notorious straight jacket. It violates the teaching of modern psychology and psychiatry and ignores the enlightened principles of good patient care which treat the patient's whole personality and not only just a sick organ. The usual net is, therefore, in very many instances completely unworkable. The only exception may be an infant's crib, which gives the child when sitting up at least some head-room.

Only lately, a Hartford manufacturer constructed a new kind of safety net, somewhat following the pattern of a mosquito net. It has the advantage of eliminating completely the traditional siderails. This new safety net is in the form of a canopy on a frame which is affixed to the bed. It allows the patient to sit up and move without the necessity of restraints, and if he accidentally should roll off the mattress, he is securely held by the cloth of the canopy. The canopy has netting on all sides. It can be opened by zippers from the outside only. Once the patient is inside this tent, he must very forcibly rip the sturdy cloth in order to get out. Both the New York Department of Hospitals and the City Fire Department advise that they, nevertheless, do not object against its use.

Despite its advantages, the cage-like appearance of this safeguard may necessitate a great deal of psychological preparation of the patient and his family. We are using one of these tents in our own institution with good results but, for psychological reasons, we dare try it only as a last resort in order to avoid restraint and old-fashioned netting.

Considering all these safeguards against falls from bed, it appears there is not yet a completely effective way of mechanical precaution. Constant watch by nurses or another conscientious human being has not yet been replaced by any ingenious gadget.

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Labor's Influence ...on Health Care Developments Part II

In seeking the highest quality medical care product for its money, labor is showing steadily increasing interest in the potentialities of group medical practice.

by Frederick D. Mott, M.D. and Roy Hudenburg

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Aims for Improved Health Care

In general, the desire of labor is to secure through the prepayment mechanism the most comprehensive health benefits that can realistically be anticipated. The term "comprehensive" is applied to health care programs with foreknowledge that the completeness of any program must be limited to an extent by its cost and limited by the bounds of practicality. Study of the economics of services and costs soon indicates that few voluntary programs can undertake at the outset such benefits as prolonged care of the bedridden patient who can no longer be benefited by active care and rehabilitation. The same applies to unlimited psychiatric care and to complete dental care.

What labor looks for at this stage is a positive and broad program of medical and hospital care on a service rather than an indemnity basis. Physicians' care in the office and home, as well as in the hospital, is considered basic. There is genuine interest in preventive services, in the full range of diagnostic and therapeutic services, for ambulatory as well as bed patients, and in full application of the concept of rehabilitation. Recently David J. McDonald, president of the United Steelworkers, put it this way in throwing down a challenge to the Medical Society of the State of Pennsylvania:

"We ask you to join with us in exploration in the development of a completely prepaid, fully insured medical care system. You must be prepared to accept the idea that such insurance is right and proper, that group practice has a place in this picture, and that preventive medicine and rehabilitation as well as diagnosis and therapy are proper parts of a medical care prepayment plan."

As another aspect of comprehensiveness, labor would like to see health care made available to all of its members without distinction so that coverage might be maintained during periods of unemployment and without continued expense to the retired worker. Again, such broad coverage is infrequently provided, because it calls on the working population for substantially increased monthly payments to support the program for the unemployed and the retired union member. Labor tends to look for really effective solutions to these problems, such as the broadening of unemployment compensation programs and the enactment of federal legislation to provide health benefits to retirees and others eligible for benefits under Social Security.

Along with comprehensiveness of care, labor is asking for high quality care. Walter Reuther states:

"Our Union wants no compromise of quality; we are not looking for bargain basement medicine. The arrangements to provide and pay for care must not conflict with the objective of high quality care; rather they must reinforce it. But we cannot accept the contention that quality is automatically lowered by any change at all in the currently prevailing pattern for practicing medicine or paying for it."

In seeking the highest quality medical care product for its money, labor is showing steadily increasing interest in the potentialities of group medical practice. The industrial worker can hardly fail to see the logic in applying our American genius for organization to the field of medical services. In our scores of good medical groups around the nation he sees the results of carefully selecting physicians, building a balanced team of personal physicians and specialists, and providing a framework of ancillary staff and planned facilities permitting the doctors to work effectively and in close and productive association. He is increasingly aware, moreover, that through linking group medical practice with prepayment, growing thousands of his confreres are learning that they can obtain virtually the full range of medical services at a cost that is not excessive.

The United Steelworkers of America is the latest of the major unions to endorse the group practice approach. At their Ninth Constitutional Convention, in 1958, delegates adopted a resolution naming as a long-range goal "The development of fully prepaid medical care plans utilizing group practice medicine in order to provide programs of complete health care for the members of our union and their families." Moreover, in a booklet recently published by the United Steelworkers to explain their social security aims, the following statement is made: "Comprehensive health care of high quality, provided through efficient group prac-

Part I (October page 42) includes the statements of labor's leaders.

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The Care of Electric Equipment and Facilities

For a safe hospital, administrators and engineers must be aware of design and maintenance of electrical systems, transformers, load centers, circuits and emergency services.

by H. S. Dorsey*
Engineer, TVA

■ THE MANY THINGS having to do with the care of electrical equipment and facilities in hospitals can be divided into two categories, *design* and *maintenance*.

Design

Too often we find that our maintenance problems are greater because someone did not give enough thought and study to the design of the electrical facilities, the selection of equipment and the problems of their maintenance. The hospital engineer must often work with the conditions given to him and must make the best of it. But many mistakes could have been avoided.

When a new hospital or an addition are being planned, it would be a wise move by the hospital board to employ a hospital engineer as a consultant to work with them and their architect in planning, laying out and specifying the electrical facilities and equipment. The hospital engineer is familiar with hospital maintenance and with equipment. He knows what problems to expect and what types of equipment are best suited to the needs of a certain type of hospital. He knows that some brands of equipment are easier to maintain than their competitors.

Some of the important items of design that will affect the care of electrical facilities and equipment are service and distribution. These questions are important:

1. What type of *service* is best, considering the over-all, long time operation? Shall service be taken at a primary (distribution voltage of the power distributor) or at a secondary voltage?

2. What will be the hospital *distribution* voltage? Three-phase, four-wire (Wye) 120/208 volts, three-phase, four-wire (Delta) 120/240 volts or three-phase, three-wire (Delta) 480 volts.

There are advantages to each of these systems of service, but it must be determined what is best suited for your particular hospital. Initial cost must be weighed with the cost of other equipment to be installed on this service. Proper design, layout and installation practices, combined with personnel safety, ease of inspection, and maintenance, are considerations.

When an underground service is desired, whether at primary or secondary voltage, install a spare dead-ended circuit. This second service may be worth its weight in gold some day should the original circuit fail. A quick reconnection at pole and main breaker restores full service to the hospital in a short time. If at all possible ask the electric utility to serve you from two separate distribution feeders. Even though served from the same main substation, main distribution feeders have been knocked out due to a wind storm, a pole knocked down by an automobile or a fault on the line.

Transformers, Load Centers

Transformer vaults and power load centers need special consideration. First they must be properly located in regard to point of entrance and proximity to the heaviest loads. You will find your electric power distributor cooperative in bringing his distribution line to an advantageous location for a service entrance. Put your main breaker as close to the point of entrance in the building as possible.

Rooms designated to house switchgear, transformers or load center cubicles must be adequate to handle the equipment safely and large enough to allow for easy inspection and maintenance. *Any room not in use and available will not do.* Good ventilation is essential to carry off the heat generated

*Deceased, June 4, 1958.

Emergency Service

We have all seen tornados, sleet storms, flash floods and other disasters which cause interruption of electric service from a few minutes to a few days. You can be without service in spite of all that is done to provide uninterrupted service. Remember that your hospitals are filled with incapacitated people who have placed their lives in your hands and have complete confidence in you to see that they have every chance to recover. Every iron lung, every piece of critical electrical equipment must be kept running even though normal service fails. This means that you must have a 100 percent reliable emergency engine generator set that will automatically take over the critical electrical load in a maximum of *eight seconds*. Only the best of equipment will do this, and only the best of maintenance and care will keep this equipment in condition to give this kind of service. The second best will not do.

A recently completed hospital opened its doors to patients and is now in operation without a workable emergency generator. Can you imagine a new hospital building complete in every detail of modern architecture, all new gleaming hospital furnishings, the latest signal and communication system, automatic controls on most everything operable, all dependent on electric service and with no emergency service. Why? Because somebody thought the second best was good enough and bought a unit cheap. It really was very expensive because it does not operate. Some internal parts are missing or broken. The irony of it all is that this unit is no longer made and parts are no longer stocked. They are looking everywhere for an old unit to get the needed parts. Suppose they do find the parts, what will happen the next time a part is needed, maybe five years from now? This hospital's patients are unprotected in an emergency. Some could die as a result of power failure.

If costs necessitate cuts in expenditures, cut someplace else besides the emergency generator set, the electric facilities and electrical wiring and equipment. Cut out some of the costly architectural embellishments, postpone the landscaping, do away with a costly underground electric service entrance. There are many ways of savings that are not nearly as detrimental to the successful operation of a hospital.

Reliable emergency service is a *must*, particularly since many are entering the Civil Defense Program. Many of our hospitals are within a target area, which means that they must be able to operate independently.

Let me suggest that most careful consideration be given to selection of emergency service equipment. Listings should be prepared for all electrical equipment, classifying it as critical, semicritical and noncritical. Emergency service should be provided for all critical equipment with no diversity factor, also for the semicritical equipment with a reasonable diversity factor. These loads can usually be handled with one *reliable* unit. If the hospital is large, multiple units should be connected in parallel to provide the necessary capacity.

from the equipment, to dissipate inflammable or explosive gases and to relieve dangerous pressures.

Need for such ventilation was recently dramatized. The incident occurred in a transformer room in a hospital with a 300 KVA, three-phase air-cooled transformer. There was no forced ventilation. The room itself was ample in size, but had only one 2 by 2 foot window and small grill in the door to allow for natural ventilation. There was far too little ventilation to allow the transformer to dissipate its heat. The ambient temperature was very high. It was recommended that a window fan controlled by a thermostat be installed in the window and the door grill enlarged.

There is yet another problem to be faced. If the transformer should become overloaded or burn out, provision must be made for replacement. The present transformer may have been skidded into the room before the concrete block partition was put up. The door is now too small to remove the transformer and so the wall must be torn down to remove and replace the transformer.

Thought should also be given to additional loads and the possible addition of a new wing to the hospital. Many hospitals are stymied today when they want to install air conditioning equipment or convert an old kitchen to an all-electric kitchen. What can be done when their electrical system is already overloaded? The transformer room will not take larger transformers, the underground conduit will not take larger conductors and there is no spare capacity in the main breaker. Somebody should have thought of this possibility. In that case one has to start from scratch, and this is extremely costly.

So when we plan service for a hospital today, let's think of tomorrow, future loads and future additions. Let us be in a position to carry these on the present installation by providing a reasonable amount of spare capacity—not less than 25 percent. Good judgment pays off if we select equipment that can easily be added to. Use standard equipment, the type of equipment that can always be purchased from leading manufacturers.

Maintenance of electrical equipment and facilities is as important as selection. First consider our electric service entrance.

If the hospital electric service enters the building underground, service whether at primary or secondary voltage is received at the power distributors' pole. The pothead and conduit on the pole and underground, as well as the conductors, are the property of the hospital and are your responsibility. They need only an annual inspection. It is important to see that manholes through which the underground service may run are well drained and kept free from standing water. If junctions are made in the manhole, inspect them semiannually to see that insulation and protective covering is holding up and undisturbed. If the conduit terminates on each side of the manhole, make sure that a heavy grounding conductor is welded to each conduit to insure a continuous ground.

The main breaker, whether for primary or secondary service, requires attention. It is your over-all protection. It must be capable of successful operation at all times. This breaker is generally an oil circuit breaker. The oil should be changed periodically, either on a

Doctor, the electric typewriter is toasting your letters again.

time schedule or after a specified number of operations. I would suggest that the oil be changed and the lugs tightened on the conductors at least every 12 months or after 15 or 20 operations. The mechanical mechanism, settings on the current trip coils, and the time delay undervoltage release device should also be inspected. If the breaker is an air circuit breaker, blow out all dust and lint and follow same procedure as above, omitting the oil. If breakers have opened during a storm, an inspection should be made to determine if there was any damage.

Circuit breakers and fusible safety switches should be opened occasionally to make sure they are operable. I have seen some that could not be opened due to corrosion. Breakers and switches are protective equipment and must protect the wiring, the load, and the operators.

Transformers

Normally, primary service transformers are owned by the local power distributor who will inspect and maintain his own equipment. Occasionally the hospital may own its own substation and in that case oil samples should be drawn off every two years and sent out for a dielectric breakdown test. If there is an indication of moisture, sludge or a darkening of the oil it should be changed. The old oil should be filtered and stored to be used as replacement when needed.

Smaller transformers (25 KVA and under) should have the oil changed every three to five years. The amounts of oil used in these smaller transformers is relatively small and hardly worth reclaiming.

A word of warning concerning oil used in transformers and breakers. Do not use oil that is not in a sealed container direct from the vendor, unless it is given a dielectric test.

Transformers should be checked for temperature and oil level once a month. All connections should be checked for corrosion, tightness and signs of overload. Records should be kept on both transformers and breakers showing date of inspections, amperes per phase and voltages, conditions at time of inspection and anything of an unusual nature noted. Next in order are semi-annual inspections of load center cubicles and distribution panels.

Feeder and branch circuit loads should be checked by an ammeter to determine any overloading of wiring and protective devices. Circuit breaker type panels should be checked, dirty contacts cleaned, weak springs renewed making sure that proper thermal elements are in use. Fused panels should be inspected to insure that the fuse clips are free from annealing, that fuses fit tightly and proper contact is made. Weak fuse contacts cause heating which soon leads to trouble. All bus bar connections, loose lugs on switches, breakers, and fuse blocks should be tightened. Look for signs of heating due to overloads.

Older hospitals often have a number of overloaded circuits and trouble is experienced with overheated feeders, branch circuits and blown fuses. Quite often these circuits can be cut in two and the load divided by installing a new feeder to divided circuit. It is sometimes found that a circuit is not overloaded, but the fuses protecting this circuit blow repeatedly. This is generally caused by the starting current of one or more motor driven pieces of equipment. The remedy for this is the use of time lag fuses designed to carry momentary high currents for motor starting but give full protection on overloads of longer duration.

Lighting

Lighting panelboards need to be inspected from time to time and their loads balanced. Most hospitals have a three-phase, four-wire system. In the case of the Delta connected service, one phase or leg is the power leg and its voltage to neutral is between 190 and 200 volts. The power leg, sometimes called the wild phase, should be plainly marked with a red marker band in each panel from which lighting or 120-volt single-phase service is taken. This is done to avoid getting overvoltage by error in connecting circuits. In the case of a Wye connection this does not exist, as 120 volt single-phase service is available from any phase to neutral.

A good maintenance man will see that his lighting circuits are well balanced between the two phases and neutral in the case of a Delta service and the three phases and neutral on the Wye service. This balance keeps from overloading any one phase and holds the current on the neutral conductor to a low value. The neutral has to carry whatever unbalance you have between phases.

It would be well to mention that exit light circuits should be served from the line side of your main secondary service switch but protected by its own fusible disconnect switch. This allows the exit lights to operate as long as there is power coming into the building.

Grounding

Weekly inspection and tests of the hospital's isolated ground electrical system should be made. Check temperature of the isolating transformer to see if it is overheating; check ground-detecting units. Make up a device with proper resistance

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by Charles U. Letourneau, M.D. and Melinda Ulveling, B.A.

Vacant Hospital Beds

— A Study of Occupancy *Part II*

THE PLANNING OF OUR HOSPITAL SYSTEM has sometimes lacked foresight. The voluntary hospital system under which we operate places a premium upon the desire and the ability of the people of a community to provide hospital facilities for themselves. Under the system of priorities established by the federal Hospital Survey and Construction Act, communities with lower priority sometimes obtain beds ahead of some more needy communities simply because of their ability to pay for them. As Roemer and Shain[1] put it: *"It is the effective demand or 'buying power' for beds which is decisive and this has little relationship to illness need."*

Planning has sometimes failed to take into consideration the local characteristics of the community. Facilities have been established sometimes which the people of the community could neither use nor pay for. For example, it is obvious from the number of empty bassinets reported that there are too many obstetrical and pediatric beds in our hospitals. In some hospitals, the financial balance sheet shows a loss because of empty obstetrical beds alone even though the rest of the institution is operating to capacity.

Changing Circumstances

In some instances, the planning was well done but circumstances, foreseeable or otherwise, caused a change in the needs of the community. The changing character of the people in a community undoubtedly affects the type of service that a hospital should provide. A rapidly developing community of young people supported by good business and industrial enterprises should require a fairly high proportion of maternity and children's services. But if circumstances should change as might occur when an industry is closed, the young people would tend to move away leaving only the older population behind. Economic changes in the population may also cause waste when a community changes from a well-to-do people to a low-income population who cannot afford the services of a hospital. Climate also contributes to the population shift. There is a gradual drift of older people towards the warmer climates. Hospitals in these areas need to provide more facilities for older people. Changes in the ethnic composition of a community where new people have different hospital customs may also result in waste. Latin Americans, for example, tend to remain a shorter time in hospitals.

Duplication of Services

One of the most important causes of vacant beds is the duplication of services. *"The elimination of duplication of hospital facilities"* was the first item recommended for study by Pennsylvania Commissioner Smith.[2] One contributing cause is competition between physicians in a community. The struggle for recognition and power often leads one or more physicians to persuade an organization to establish another hospital so that they can compete with rival physicians because the latter have gained the upper hand in the existing hospital facility. Thus, disputes between general practitioners and specialists, clinics and solo practitioners, union doctors and independent doctors sometimes lead to duplication of facilities. Where there is more than one hospital in a community, physicians may persuade the administration of one hospital to duplicate facilities existing in another for the sole purpose of gaining prestige and status for the hospital (and the physicians in it) even though they are not necessary for service to the community.

Political rivalry is a growing cause of duplication of facilities. There are some communities where the same facilities may exist in a federal government hospital and in a state or local government institution with neither being used to the maximum of efficiency. Ethnic and religious groups often vie with each other to provide hospital facilities for the communities that they serve —often resulting in empty beds in the less popular institution. Civic pride may also lead to duplication.

Granted it is much more expensive to have such wastage, yet who shall say that the people of a community are not better served by such competition? Moreover, the Christian churches have always recognized service to the sick as a legitimate apostolic activity which is a part of their ministry.

Granted that the capitalistic system of free competition is wasteful of resources, it cannot be denied that it has produced the best medical services in the world and has achieved the greatest scientific progress the world has ever known. Although elimination of waste is desirable as a rule, we should ponder the choice between wasteful

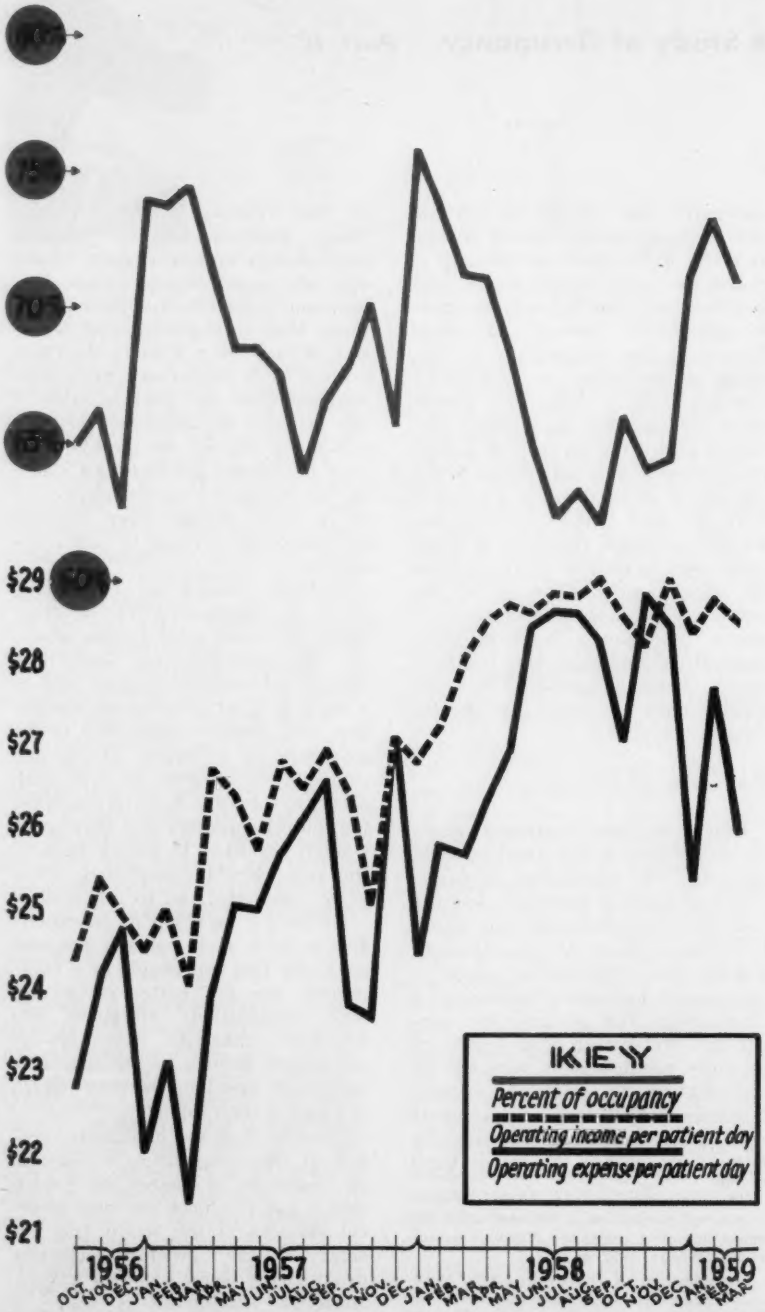
[1] M. I. Roemer and M. Shain; Hospital monograph series no. 6, hospital utilization under insurance. American Hospital Association, Chicago, 1959. p. 14

[2] Adjudication of Francis R. Smith, Insurance Commissioner, Commonwealth of Pennsylvania; In the matter of the filing of the associated hospital service of Philadelphia. April 15, 1958. p. 23

excellence and efficient mediocrity while we strive for efficient excellence.

Overspecialization

The matter of specialization of hospital beds is something that is definitely in need of review. Doctor Rufus Rorem has already called attention to this situation in a suggestion for more effective utilization of beds by a reduction in the number of beds per room to permit alternative use by various types of patients.[9] However the Joint Commission on Accreditation of Hospitals has recommended that hospitals larger than 75 beds in size should contain the departments of medicine, surgery and obstetrics. Although it is a fairly simple matter to interchange medical and surgical beds, the design and construction of most hospitals makes it almost impossible to use vacant maternity beds for anything else but obstetrics. To quote Roemer and Shain, *"Unless there is some elasticity between wards, one section of a hospital may be half empty, while another is plagued with a waiting list."*[10]



Graph 1. The national average occupancy, income and expenses for 30 months for hospitals of 1 to 100 beds.

An Interpretation of

■ WHILE COSTS have risen gradually,* the greatest surges have occurred at points of lowest occupancy. Income has also risen gradually; however, this was in reverse order with less income at lowest points of occupancy. Even at points of lowest income and occupancy and highest costs, the national average gives an encouraging picture of operating in the black. When the figures are broken down into areas, however, it appears that seasonal losses of one geographical area may be compensated for by the income of another area whose dip in occupancy occurs earlier or later in the year.

The National Average for 30 months — 1 to 100 beds

The yearly national patterns (graph 1) show seasonal variations in occupancy with the low occupancy occurring in the summer months; there is a slight rise in the fall months and then a decline in December. On the national scene these smaller hospitals operated in the black during the first six months of the year but a gradual decrease in occupancy accompanied by increasing costs during the last six months of each year created some actual losses.

The Area Averages for the year 1958

A fairly steady margin of operation in small hospitals was maintained during the early months of

*All of these figures are a part of How's Business, published each month as an exclusive service of HOSPITAL MANAGEMENT.

Graphs of the study of hospitals 101 to 225 beds and of hospitals 226 beds and over will appear in Part III of this article in the December issue of HOSPITAL MANAGEMENT.

The Northeast Ohio study indicated that the obstetrical beds in Cuyahoga county operated at an occupancy of 77 percent but this represented the total of all hospitals. A substantial number of hospitals operated at much less than 70 percent of occupancy but were balanced by others that operated at more than 90 percent.[11] Vacant obstetrical beds accounted for 22 percent of the total of unoccupied beds in Cuyahoga county which presents a better picture than one finds on the national level. According to the statistics of the American Hospital Association for the State of Ohio, the average occupancy of bassinets is 59 percent compared to the nationals figures which show an occupancy of only 47.5 percent. In all likelihood, vacant obstetrical beds are much higher for continental United States than for Northeast Ohio.

Although the problem is less acute in other departments of the hospitals, there are still places where beds are not interchangeable. There are some hospitals where it would create a crisis if surgical patients were assigned to beds in the

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the Graphs

the year while the percentage of occupancy in these hospitals averaged in the 70s (excepting the Mountain States and the Pacific Coast areas whose percentages of occupancy were somewhat lower). During the latter half of the year the average percentage of occupancy was in the 60s. During these months in all areas the margin for operation was decreased and in all of these areas an actual operating loss occurred at some point during the last six months of 1958 during either the summer or December slumps in occupancy.

New England — the low occupancy month was July with 60.17 percent.

Middle Atlantic — average occupancy dropped to 49.98 percent in September.

South Atlantic — the low occupancy occurred in December when it reached 63.71 percent.

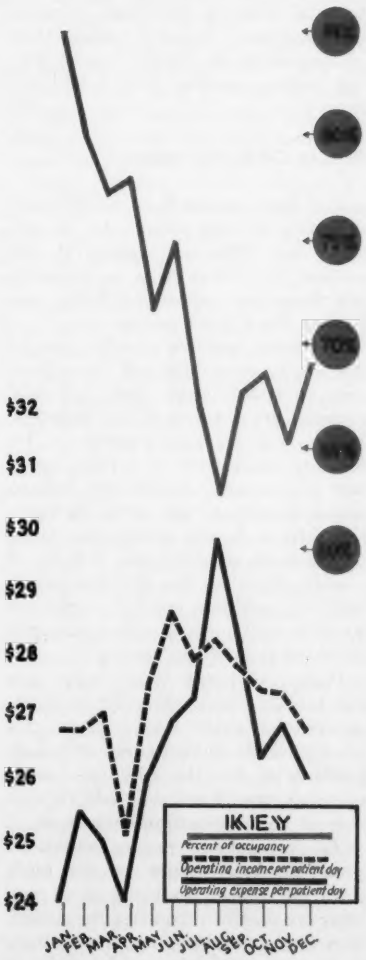
South Central — the low occupancy reached 65.61 in November.

East North Central—(graph 2) regained some ground the last three months after operating in the red during August and September; but the margin of operation was less steady during the last six months of the year. The high occupancy was 84.97 percent in January and the low was 62.80 percent in August.

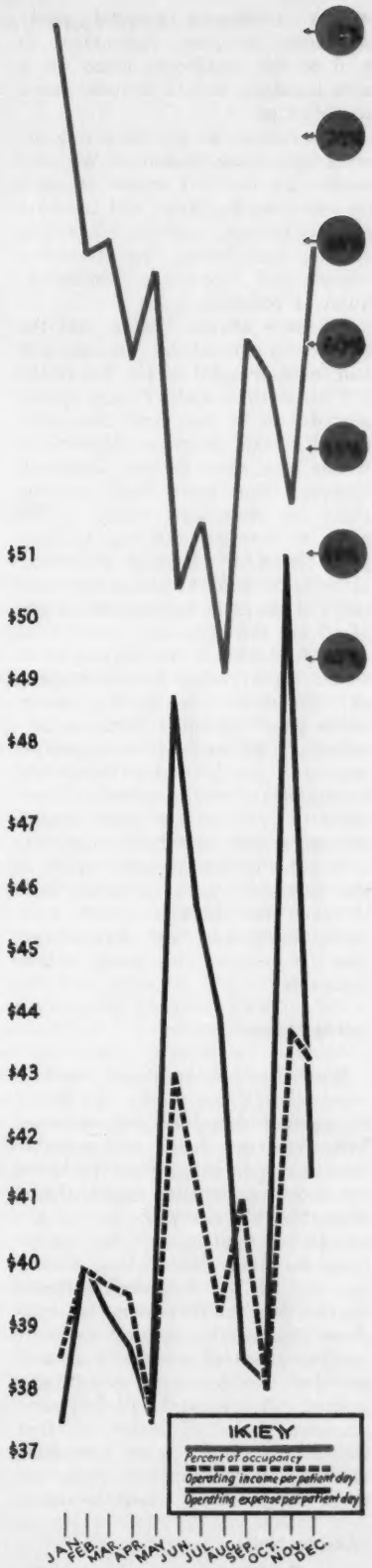
West North Central — the high occupancy months were January, 74.04 and March 73.01. This area operated in the black for the first five months but rising costs cut into this margin and an actual loss occurred in August, 1958.

Mountain States — occupancy dropped below 55 percent during the months of June, July and September.

Pacific Coast — operated in the red (graph 3) for the six months of May, June, July, August, October and November, during which time occupancy dropped as low as 44.29 percent in the month of August.



Graph 2. The East North Central area average occupancy, income and expenses for 1958 for hospitals of 1 to 100 beds.



Graph 3. The Pacific Coast area average occupancy, income and expenses for 1958 for hospitals of 1 to 100 beds.

QUIET FOR SALE

■ ANY EXTENSIVE hospital modernization program nowadays, as well as the architect's plans for a new building, should include sound conditioning.

As a nation, we are becoming increasingly noise conscious. We recognize the harmful effects of noise on our everyday lives, and are constantly taking steps to make our streets, our homes, our factories, offices and stores as healthfully quiet as possible.

We have always known that the sick room should be the quietest and most peaceful of all; the *HOSPITAL ZONE—QUIET* sign represented one of the very first concerted efforts at noise abatement. It has long since become apparent, however, that more than warning signs are necessary; many of the noise sources surrounding the hospital today are beyond individual or even community control, and some of the most bothersome sounds of all are the hospital's own noises.

Unfortunately, the approach to sound conditioning, in the hospital as elsewhere, sometimes shows more good intention than understanding. All too often corrective measures are limited to acoustical treatment of the hospital's corridors; the ceilings are covered with acoustical tiles and that is that. This is helpful, of course, since much of the hospital's noise problem does involve the corridors. But even casual reflection will demonstrate that the problem goes much farther than this.

Inside Noises

What about the patients' rooms—especially those "semi-private" rooms with four, five, six or more beds—and the radio and portable television sets with which the bored convalescing patients regale themselves? A TV set with the volume turned up loud enough for everybody in Room 315 to hear clearly can disturb all the other patients on the floor in that wing (at least those who aren't watching the same program) unless the rooms as well as the corridor are acoustically treated. The racket will be compounded if the occupants of other rooms are tuned in to something else, for they'll have to turn up their volume that much louder.

Outside Noises

In addition, there are the noises from outside, signs or no signs—the clatter of refuse cans, of trucks loading and unloading supplies, traffic noises and perhaps the roar of airplanes. Also there are noisy operations and locations within the hospital such as the main kitchen, diet kitchens, laundry, mechanical equipment areas, utility rooms, dining rooms, waiting rooms and offices.

Reduce Offending Noises

The first approach to sound conditioning always should be to reduce the offending noises at the source. The next step is isolation, which means separating noisy activities from quiet areas.

A classic example of what should *not* be done is afforded by a certain hospital that had patients' rooms directly over the laundry, which was in the basement. The laundry machinery was very noisy, and the laundry employees had to speak loudly at each other to make themselves heard above the noise of washers and mangles which, of course, added to the din. The result was a condition hardly conducive to the well-being of the patients over the immediate vicinity.

Proper planning would have put the laundry in a different location, where the noise would cause the least possible disturbance. The same holds true for the kitchens. Such areas, it need hardly be added, also should have acoustical treatment.

As for outside noises, the hospital building should be set back from the street, to make it as remote as possible from traffic noises. The more landscaping the better; thick-foliaged trees and shrubbery not only have a decorative value but also serve as a partial sound barrier. Unfortunately, in an urban area, spacious, well-landscaped grounds may be out of the question. In any event, it should be borne in mind that noisy operations, like handling garbage cans and oxygen tanks, will be noisiest because of reverberation, if performed in a courtyard.

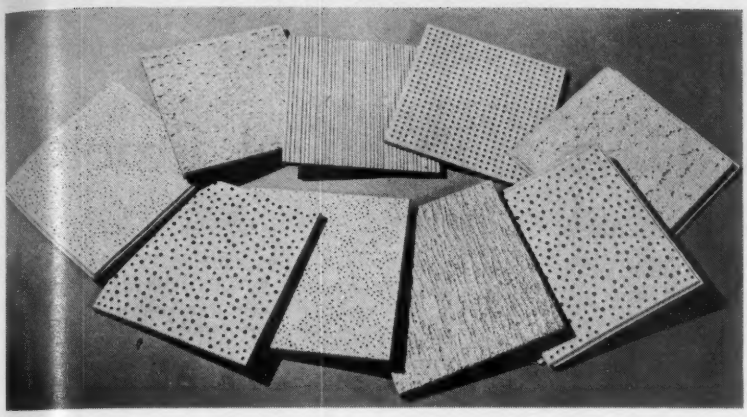
Reverberation (what makes noise noisy) is the heart of the noise problem, whether the noise originates indoors or outdoors. The remedy for reverberation is absorption, which is the function of all the commercial acoustical materials, regardless of type or design.

Without absorptive treatment, the interior of the hospital is, acoustically, a chamber of "sound horrors." The floors, painted plaster walls, the unbroken surfaces of the flush doors, the large glass areas of the windows—all reflect sound as a mirror reflects light. Up to 99 percent of the sounds that strike them bounce back into the room, and they continue to bounce and ricochet from surface to surface until their energy dies out.

The iteration and reiteration of the original sound amplifies it, distorts it, prolongs it and spreads it over an expanded area. Everyone has had the experience of hearing sound travel from one end of a corridor to the other end (and into rooms adjacent to the corridor). Also the observer notes that spoken words in a sound-reflecting corridor or rooms are not easily discernable.

Some of the same sort of thing is to blame for the television in Room 315 being turned up so loud; reverberation blurs the sound so that the patients turn up the volume to compensate; and the same reverberate condition makes the residual sound louder still, to the discomfiture of the other patients.

Mr. Washburn is president, Acoustical Materials Association.



by Paul Washburn

In really noisy areas, excessive reverberation can produce a reasonable facsimile of pandemonium.

Your living room at home may have a comfortable amount of sound absorption because of normal furniture. On the other hand the only sound absorption in the furnishings of a typical hospital room is that afforded by the bedding, draperies or curtains, perhaps a cushioned chair or two and the patients themselves.

Let the Experts Do It

Wherever there is insufficient sound absorption, the remedy is to cover a sufficiently large area or surface in the reverberant space with a suitable acoustical material to break up the boisterous echoes. But diagnosing the noise problems of a given hospital and prescribing for their relief is a job for an expert.

A current bulletin of the Acoustical Materials Association,* which represents all the major manufacturers in the field, lists and describes no less than 137 products, grouped into 12 different types and marketed under 64 different trade names. These range from the familiar monolithic tiles with perforated or fissured face to large acoustical panels and heavy duty assembled units. Some are made of cellulose (wood or bagasse) fibers, some of mineral wool, some of glass fibers, some of cork granules. The assembled units consist of a mineral fiber pad or blanket faced with perforated metal or asbestos board.

Each type of product has its own special characteristics, but all are highly efficient in soaking up noise.

*57 E. 55th Street, New York 22, N.Y.

Acoustical Tiles Are Versatile

■ EXCEPT FOR THE FACT that they all absorb sound, acoustical materials differ from one another. For instance, some are able to absorb more sound than others. Some are made from substances that cannot burn, and some are designed for a particular method of installation.

Wood fiber tiles are probably the most economical materials on the market. They are made in a low density composition and may be fissured or perforated in a variety of attractive designs. Wood fiber tiles come in different thicknesses and sizes, and can be cemented to plaster, concrete, wood, or gypsum board surfaces, or nailed onto wood furring strips. Some wood fiber tiles are available with a flame resistant finish.

Mineral tiles are incombustible and for this reason are more commonly found in commercial and institutional buildings. Fissured tiles of compressed mineral wool are particularly suited to hospital areas where appearance is of primary concern. These materials are styled to resemble authentic travertine marble, and are often called the most attractive of acoustical products. One manufacturer has recently introduced a line of fissured mineral wool tiles which contain clusters of tiny golden or silver colored metallic chips imbedded in the tile fissures.

In the moderate price range, along with fissured wool tiles, are mineral fiber tiles, also available in a variety of attractive patterns. One of these materials has striated, or grooved surface design that forms strong directional lines of high light and deep shadow on the ceiling. Another offers an unusual lace-like arrangement of tiny surface perforations which create an interesting free-flowing effect in an installed ceiling.

Mineral acoustical tiles are factory-finished with a washable white paint and are installed by cementing or mechanical suspension. If necessary, the materials can be repainted with a good grade of oil base paint.

The metal pan type acoustical materials are generally conceded to be the most efficient acoustically. They consist of a perforated metal pan unit to provide structural strength and a noise quieting mineral wood pad for backing. The metal pan ceilings are recommended especially for installations that require the highest possible degree of sound absorption.

Rated fire protection is also available in an acoustical material. A new mineral tile, when installed in a special mechanical suspension system, is able to resist dangerous transmission of heat and flame in the event of fire. It is designed to help check the spread of fire to other areas of the building without the use of intermediate fire-stops above, and in addition to the finished acoustical ceiling.

Maintenance of most acoustical materials is a simple matter. They require no more upkeep than ordinary ceiling materials. An occasional wiping with a damp cloth or dusting with a vacuum cleaner is sufficient to keep acoustical ceilings clean for years. While most materials are considered washable, they should not be subjected to heavy quantities of water which might be absorbed by the fibrous or porous tiles. The metal pan ceiling materials may be scrubbed with a stiff brush, if care is taken to avoid forcing water into the holes. Stubborn spots on wood fiber products can be removed by ordinary wallpaper cleaner or art gum eraser.

—From Armstrong Cork Company, Lancaster, Pa.

Do you Have a Technical Problem

by James V. Campbell
Chief of Plant Maintenance Services
Board of Texas State Hospitals and Special Schools

■ PROBLEMS IN THE HOSPITAL MAINTENANCE field are many and varied. Among those frequently encountered in day-to-day operations are engineering or technical problems which in themselves cover the fields of mechanics, electricity, sanitation, safety, laundry, structures, roofs, paints, roads and grounds, to mention just a few. And then, in addition, you encounter a host of other problems such as operating problems, budgeting, planning and scheduling, maintenance records, supplies, cost control, inventory control, and personnel problems. Even though these in the latter group are not of an engineering or technical nature, the hospital engineer is frequently called upon to find a workable solution to such of these problems as affect his part of the hospital operation.

This discussion is going to touch only on sources of help in finding solutions to engineering or technical problems and not to such problems as operating and personnel problems.

In solving problems the hospital engineer is sometimes forced to settle at least temporarily for solutions which do not *completely* solve the problem but which do reduce the frequency with which the problem occurs. However, a good engineer will not repeatedly be satisfied with stop-gap or partial solutions.

Have Confidence

Don't be too anxious to throw in the towel and call for help. After all, you no doubt have an intimate knowledge and feeling for the operation and maintenance of equipment and buildings that only years of experience can produce. By virtue of this fact you are in the driver's seat as far as maintenance problems are concerned. Develop self-confidence in your own initiative and ability. Don't sell yourself short.

On the other hand, even the most capable engineer sometimes finds that he needs help, and usually he needs it in a hurry. It is then usually too late to start thinking about what he should have done a year or two years ago in preparation for the day when he would need help. It is rare that the engineer can find a solution or a significant source of help to a specific problem in a short time unless he has made preparations before hand. Therefore, he must have in mind or have available certain sources of help upon which he can call when needed.

Equipment Records

Have available all information possible pertaining to a particular piece of equipment, such as the name of the manufacturer, the type, style, model, capacity, size, shop order number, serial number, date of manufacture, date installed, registration numbers, codes under which this equipment was built, service history, and all other such information which it is possible to develop.

In our system, we operate 16 laundries which launder more than 33 million pounds of clothing and linens per year for approximately 25,000 patients. In this file there is listed every piece of laundry equipment in the hospital system along with such basic information as will clearly identify each piece of equipment to the manufacturer when ordering parts or requesting information. Also shown is a summary of the service history or repair record for each piece of equipment. This record is a valuable source of information in analyzing breakdowns on equipment and in comparing the performance of different manufacturer's equipment.

Here we have the record on a piece of equipment on which the belt drive failed eight times in nine months while the record for another piece of equipment in the same laundry, installed at the same time, same size, but of a different manufacturer, shows only one belt drive failure in more than two years. You can draw your own conclusions as to which equipment we now favor, and we can support our recommendation with the actual repair records of the two pieces of equipment. We have helped ourselves solve a problem by keeping these records.

Keep Blue Print File

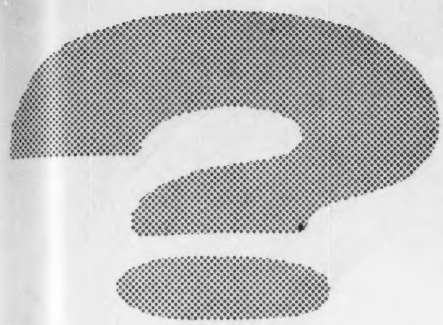
Develop a complete set of blueprints on all buildings, equipment, and utilities. If you are in an old building and a blue print file has not been properly kept through the years, you may have difficulty in locating all the prints. However, this should not discourage you from trying. Contact the engineer, architect, and contractor who constructed the hospital. Check with your hospital administrator and all other offices where records might be kept. Sometimes blueprints are located in the most peculiar and unlikely locations.

As your list of blueprints and other basic information grows, keep them properly filed and carefully protected. Careless use and improper care will completely destroy valuable records in a short time.

Obviously, it would be ridiculous to wait until you are confronted with a problem on which you need information and then say, "I think I'll start a blueprint file". Don't Wait! Start Now! It may be later than you think.

Read Advertising Publications

Frequently, the solution to a problem which the engineer had previously thought unsolvable becomes almost obvious once he has gathered and studied the proper information. Outside sources of help and information are numerous. There are such sources as advertising literature, magazine articles, trade publications, journals, handbooks, codes, manuals, textbooks,



Find the answers *before* you need them!

engineering reports and a host of other publications. It is unfortunate, but nevertheless true, that some of the *advertising* literature must be read and considered with caution. After reading a particularly convincing piece of advertising matter, more than one unwary engineer has found that he has a storeroom full of a highly advertised adhesive material, but the acoustical blocks still fall off the ceiling.

On the other hand, much of the technical literature and information which is in wide circulation today is published and distributed by manufacturing concerns.

Several examples of the different types of publications which are representative of the many sources from which helpful information may be obtained, follows.

1. *Manufacturers' Publications.*

a) Minneapolis-Honeywell—This is a refrence manual put out by a large manufacturer of instruments and controls for the installer and service man on air conditioning controls. It is divided into eight sections with the first devoted to general information and the other seven sections devoted to the various types of controls. Each section contains detailed information on the selections, installation, wiring, adjustment, and trouble shooting of the various controls.

b) Garlock—This is a catalog published by a large manufacturer of gasket material and packing materials. Some advertising matter is included in the catalog but, for the most part, it contains factual information which applies to all packing and gasket materials and not just to the product of this particular manufacturer. One very useful chart shows the effect of various gases and liquids on base materials commonly used in packings and gaskets.

Another chart gives recommendations for packing applications in many different services such as steam, water, air, gasoline and oil, gas, acids and caustics, and ammonia.

c) B & W—A third type of manufacturers' bulletin, and one which contains no advertising matter at all, is a technical article entitled "Eleven Ways to Avoid Boiler Table Corrosion" written by the chief metallurgist of one of the largest boiler manufacturers in the world.

Another publication by the same company is an article on the "Cause and Prevention of Heating Tube Failures."

d) Crane—one of the world's largest manufacturers of valves and fittings has a book entitled "Combatting Corrosion in Industrial Process Piping." The first section discusses the theory of corrosion—how corrosion occurs and what causes corrosion to occur. The second section discusses piping materials and the third section discusses corrosive fluids. The last section contains recommendations for combatting corrosion in piping.

2. *Construction Codes and Safety Codes.*

Other value sources of help and information are the various construction codes and safety codes. As examples of this type of information it is well to mention three major sections of the ASME Boiler and Pressure Vessel Code. Almost all boilers in use today are manufactured according to the ASME Code. Furthermore, in Texas, all boilers must be repaired in accordance with the provisions of this code as a matter of state law.

The first section of the code covers the construction, materials, testing, and repair of power boilers.

Section eight discusses similar topics for all vessels and tanks classed as unfired pressure vessels.

Still another section on "Suggested Rules for Care of Power Boilers" covers such topics as rules for routine operation; operating and maintaining boiler appliances; rules for inspection; prevention of boiler failures; installation; operating and maintaining boiler auxiliaries; control of chemical conditions.

3. *Handbooks*

A third type of reference book is the so-called handbook put out by many manufacturers on floor maintenance procedures for terrazzo floors, linoleum floors, rubber tile, asphalt tile, vinyl plastic, wood floors (both new and old), concrete floors, stain removal, and conductive floors.

These handbooks describe va-

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Good Sources for Helpful Information

American Society of Mechanical Engineers
29 West 39th St.
New York 18, N.Y.

Babcock and Wilcox Co.
161 E. 42nd St.
New York 17, N.Y.

Betz Laboratories, Inc.
Gillingham and Worth St.
Philadelphia 2, Pa.

Crane Company
836 S. Michigan Ave.
Chicago 5, Ill.

The Garlock Packing Company
402 Main St.
Palmyra, N.Y.

Industrial Sanitation Research Foundation
Louisville, Ky.

Minneapolis-Honeywell Regulator Company
2747 Fourth Avenue South
Minneapolis 8, Minn.

Plant Engineering Practice
booklet published by
McGraw-Hill Publishing Co., Inc.
330 W. 42nd St.
New York 36, N.Y.

Superintendent of Documents
U. S. Government Printing Office
Washington 25, D.C.

■ A STUDY of water conditioning as it applies to water treatment for air conditioning, and boiler feedwater treatment, is quite comprehensive. There are some areas of similarity in the fundamentals of each phase of water conditioning, and so there is some justification in treating both in a single study.

Water, What Is It?

The water we speak of is really a solution of salts and dissolved gases. It is, therefore, more true to say that we are dealing with various water solutions of these dissolved minerals and dissolved gases, which may be in combinations whose number can reach infinity. Each solution is a different problem, because it presents a different combination of the various water soluble minerals and dissolved gases.

It would be well to point out the general objectives of water conditioning for both air conditioning and boiler equipment. They are, *the prevention of deposit formation and the prevention of corrosion.* Since both systems are largely comprised of metal, corrosion is common to both. Since both systems have to do with the evaporation and concentration of these water solutions of minerals, scale and deposit formations are also common to both. It is really only the wide difference in temperature ranges that makes them cases apart. The constantly steaming tea-kettle on the old fashioned kitchen range is an example of scale formation that is well known. Water containing these minerals was added constantly to this old tea-kettle, and as it steamed away, the water solution of minerals concentrated, the physical and chemical reactions took place, and the scale settled down on the bottom of the kettle. Eventually, this scale became thick enough, so that the water in the kettle no longer rapidly absorbed the heat that was being applied to the bottom. The kettle bottom burned. This is precisely what happens when scale is allowed to form in a boiler system. The recirculating water no longer can cool the metal, and eventually the hot gases and fire on the furnace side of the boiler heat the steel to a point where it bags, and a tube failure is experienced.

Unretouched photo of boiler feed line clogged with calcium carbonate deposits.

In between the time when the waterside metal is free from scale, and the point at which scale becomes so heavy and of such texture as to promote burning, a steady decrease in heat transfer is experienced, and less steam is formed for each BTU of fuel expended. The same situation is true in the air conditioning and/or cooling water processes. The major difference being that the cooling water systems never reach temperatures that will promote metal failure from scale formation. Nonetheless, the loss in efficiency here is critical, and makes it a problem of worthy attention.

Corrosion

Corrosion processes are identical in both systems. In the boiler systems, much can be done to remove dissolved gases, particularly dissolved oxygen, commonly found in most makeup waters. This is done by means of pre-heating the water through deaerating type heaters, and venting the corrosion promoting gases to the atmosphere. Deaeration, however, does very little to remove the carbon dioxide content from the water. Singularly enough, the carbon dioxide has very little corrosive effect in the boiler proper, it is tied-up in alkaline salts, known as bicarbonates and carbonates, and these are only broken down at the higher temperatures encountered in the boiler system to give up the captured CO_2. The CO_2 is removed from the boiler with the steam, and it does not become active and effective until it is recondensed in the return steam condensate. At that point, this gas becomes very active and results in the millions of dollars expended each year to replace return steam condensate lines. In the cooling water systems, such as those used for refrigeration and air conditioning, the very nature of the system provides optimum conditions for the embodiment of dissolved oxygen. This is true because the water is usually cooled through an evaporative condenser, or one of the many types of atmospheric or mechanical cooling towers. With the elaborate spraying system in these units, the water droplets have a maximum area exposed to the air and do pick up sufficient quantities

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Mr. MacLean is district sales manager, Dearborn Chemical Co. Appreciation is expressed to the Research Laboratory, Dearborn Chemical Co., for the use of the illustrations.

Presented at the Tennessee Hospital Engineers' Meeting, in Nashville.

Water Treatment Fundamentals

Part I

FOR AIR CONDITIONING AND STEAM BOILER EQUIPMENT

by G. E. MacLean

Unretouched photo showing typical return line corrosive action resulting from carbonic acid and dissolved oxygen in condensate.

of dissolved oxygen to render the water quite corrosive. Having pointed out the things common to each system, we will now proceed to treat each subject separately and in its own perspective.

Restating again our objectives in the conditioning of water, or water solutions for the steam and water cycle of a boiler operation, they are the prevention of scale or mineral deposit, and the prevention of corrosion throughout the entire system, which will include the piping, auxiliaries (such as a deaerating type heater), feedwater pumps, waterside surfaces of the boiler proper and the return condensate system. The general characteristics of the three usual sources of water available are:

1. *Well water sources*—usually quite free from dissolved oxygen, but this advantage is off-set by the presence of free carbon dioxide, and unstable iron compounds and, in some rare cases, sulfur. These waters usually contain varying amounts of calcium and magnesium salts which comprise the majority of hardness minerals, and are usually present in sufficient quantities, so that they require treatment attention.

2. *Lake water sources*—usually characterized by the presence of calcium and magnesium salts, and to a greater, or lesser extent, dissolved oxygen, depending on the surface exposure and turbulence.

3. *River water sources*—present their difficulties in the form of suspended matter, which includes organics supplied by decaying wood, leaves, and today, in increasing amounts, human waste and sewage products. Because this water flows, and is more turbulent than the other two sources, the dissolved oxygen content is usually at a higher level. Since the water flows over mineral formations it readily picks up calcium, magnesium, iron, and, in some cases, a very detrimental element called manganese.

There is little that one can do to change the source of his water supply and, if a choice is available, either choice only exchanges one difficulty for another and in most cases retains to a greater, or lesser degree, the scale forming qualities of any source of supply. We must, therefore, be reconciled to a treatment program.

It was not too many years ago that the pretreatment of these water supplies was the exception. Regardless of the water solution characteristics either no chemicals were added to the system, and the operators were resigned to periodically removing the scale mechanically, or to removing part of the boiler internals completely and replacing them with new equipment. We have progressed today to a point where there is available a means of pretreating practically any water source so that it can be used with safety and efficiency in any process of steam generation. It would be impossible within the scope of this paper to discuss in detail each phase of pretreatment of water. We would like to cover these processes basically and say something of the general characteristics and advantages.

The pretreatment of water for the removal of scale forming minerals is divided into two general groups. The first is that of ion exchange. To prepare for a discussion of ion exchange treatment, something should be said about the basic con-

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Part II Personnel

Factors of Production in Hospital Management

by Harvey Schoenfeld, F.A.C.H.A., F.A.P.H.A.

Director, Barnert Memorial Hospital
Paterson, New Jersey

Part I (p. 39 October) covered machines, materials, men and their basic needs as factors in management.

The supervisor (manager or executive), key person in management, uses the functions of supervision to vitalize and optimize the organization. These functions include:

Planning, organizing, training, delegation, coordination, motivation, control, discipline, follow-up and evaluation.

Although each of these is essential, we shall emphasize here only four of the functions which face administrators today as major problems. They appear to be basic to the success of every supervisor.

Planning

The first function, planning, is absolutely essential to all fields of human endeavor. It goes on all the time as a mental process in human beings. Successful results of planning lies in how it is developed. Good planning, we have learned, insures success. Poor planning causes delay, frustration, waste and failure. Planning as a function comes in several types; viz., short-range planning, long-range planning, personal planning, and organizational planning.

Not complicated, the technique of good planning should follow the following pattern:

1. Determine the objectives desired.
2. Analyze the quantitative and qualitative needs for the four factors necessary to reach the objectives. Here the planner should ask himself the questions: how? what? where? when? who? why?
3. Develop your approach or solution.
4. Establish time schedules. Life is based on time units and its inexorable passage must be reckoned with.
5. Train yourself or others who are part of the plan.
6. Install the plan. Obtain necessary clearances. Issue clear cut orders, preferably in writing and with the participation of those who will carry them out.
7. Install controls so that the supervisor is informed of the progress and the results of the plan.
8. Inspect (follow up) the results and evaluate them in relation to the plan to insure adherence to the plan and its time schedule.

Training

The second function is that of training. This must be an on-going project for managers. In the dynamic field of administration, there must be continual learning, adopting new schedules and attitudes necessary in carrying out the vital job of caring for people. It is too easy to work oneself into a rut. The outstanding supervisor is one who has learned that learning never stops and who has conveyed this fact to his associates, his subordinates and his superiors. There are many ways to training and much has been written about it that should be reviewed by the interested executive.

Coordination

The third function of vital importance is that of coordination. This is the heart of progressive management. It is the harmonious and effective teamwork of all the factors of production. It is a fundamental principle of organization. The coordination function helps to prevent delays and serious errors. It is an important factor in establishing the morale level of the organization. Coordination depends upon understanding of the mission of the hospital and the willingness on the part of all to subjugate personal desires in the light of that mission.

As a technique, the coordination function may be carried out in several ways:

1. Brief conferences with subordinates involved in the development of plans, solutions to problems, or consideration of proposals.
2. Frequent personal follow-up and review by the supervisor.
3. Delegation of authority in keeping with the responsibility of those close to the point of contact with problems.
4. The use of small committees to consider problems or projects.
5. The use of controls such as policies, procedures, written periodic reports, systems, periodic statistical reports and analyses, telephone reports, memoranda.

Please turn to page 132

Who's Who

SISTER M. ADELE, R.N.—former administrator of Mercy Hospital, Brownsville, Texas has assumed the duties of administrator of Mercy Hospital, Laredo. SISTER M. IMELDA, former administrator of the Laredo Mercy Hospital has been transferred to St. John's Hospital, St. Louis, Missouri. SISTER M. AMBROSE has been named to succeed Sister M. Adele at Brownsville.

ADLINGTON, BRIAN—administrative assistant in charge of purchasing at Cedars of Lebanon Hospital, Los Angeles, California has been appointed assistant administrative director.

ASTIN, CARDEN M. See PURDY notice.

BAILEY, DR. PEARCE—director of the National Institute of Neurological Diseases and Blindness for the past eight years in Bethesda, Maryland has been appointed director of the Institute's new international Neurological Research Program. DR. RICHARD L. MASLAND, now assistant director, will succeed Dr. Bailey as director of the Institute.

BLOSSOM, CORA C., R.N.—has been appointed administrator of the Flagler Clinic and Hospital, Bunnell, Florida.

BOOTH MILTON C.—named assistant administrator and comptroller of Mobile Infirmary, Mobile, Alabama.

BROTHERTON, GEORGE—resigned as administrator of the John Peter Smith Hospital, Fort Worth, Texas.

CAMPBELL, ALAN B.—has accepted the position of administrator of the Northwest Suburban Community Hospital, Arlington Heights, Illinois. He succeeds WILLIAM S. NICHOLS. Mr. Campbell was formerly administrator of Richland Memorial Hospital, Olney.

DAVIDSON, DR. JOSEPH W., JR.—has been named director of Medical Education at Methodist Hospital, Dallas, Texas.

DAVIS, MRS. J. B.—has resigned as administrator of the Kissimmee Hospital, Kissimmee, Florida. BRUCE M. THOGMARTIN, has been named to succeed Mrs. Davis.

DOHLEMAN, LEE—has resigned as administrator of the Fairbury (Illinois) Hospital.

DRESSER, EARL G.—resigned as administrator of McDonough District Hospital, Macomb, Illinois to become administrator of Methodist Hospital, Madison, Wisconsin.

ELLIOTT, GORDON W.—assistant administrator of the Mercer Hospital, Trenton, New Jersey has been appointed administrator of Riverside Hospital in Boonton.

SISTER MARY ESTHER—administrator of Our Lady of Lourdes Hospital, Pasco, Washington has been transferred to St. Mary's Hospital, Tucson, Arizona as administrator of that hospital. SISTER MARY STEPHEN of Los Angeles, California succeeds her at Pasco.

SISTER M. EVANGELIST. See SISTER MARY MARGARET notice.

FOSMIRE, FRANCIS G.—accepted a position as administrative assistant to the director of Professional Administrative Services at the Jackson Memorial Hospital, Miami, Florida.

GEYER, GERALD F.—appointed administrator of the Gaines County Hospital, Seminole, Texas. He was formerly assistant administrator of the Montgomery County Hospital, Conroe, Texas.

GUILBEAU, JOSEPH A., M.D.—appointed administrator of the Hohf Clinic and Hospital, Victoria, Texas.

HENDERSON, WILL J.—formerly assistant administrator of the University of California Los Angeles Medical Center, Los Angeles, California has been appointed administrator of the Kauikeolani Children's Hospital and Rehabilitation Center of Hawaii at Honolulu, Hawaii.

HOWELL, GLENN—administrator of Hood River Memorial Hospital in Hood River, Oregon has been selected as superintendent of the State of Oregon Mid-Columbia Home in The Dalles.

SISTER M. INNOCENT, R.S.M.—is the new administrator of Holy Cross Hospital, Fort Lauderdale, Florida.

JACKSON, CARL S.—has been named administrator of the Reagan Memorial Hospital, Big Lake, Texas.

JARRETT, CHARLES F.—has been appointed assistant administrator of Memorial Hospital, Charleston, West Virginia.

JENKINS, LAWSON—appointed administrator of the Lindsay Municipal Hospital, Lindsay, California. He is a graduate of the program in hospital administration, Northwestern University.

JORDAN, L. R.—formerly assistant superintendent of Duke University Medical Center, Gainesville, Florida has been appointed director of the Teaching Hospital and Clinics at the University of Florida.

KREMBS, GERHARD A.—administrator of the Bayonne Hospital, Bayonne, New Jersey has resigned to become administrator of Binghamton (New York) City Hospital.

LOCKE, WILLIAM D.—selected as assistant administrator of McKeesport Hospital, McKeesport, Pennsylvania.

MAISLIN, ISADORE—appointed assistant director of Mt. Sinai Hospital, Miami Beach, Florida.

SISTER MARY MARGARET—named administrator and director of nursing service for St. Joseph Hospital, Meridian, Mississippi. She succeeds SISTER M. EVANGELIST.

MASLAND, DR. RICHARD L. See BAILEY notice.

MILLER, FLOYD—resigned as administrator of the Belle Glade (Florida) Memorial Hospital.

Arnold Mouish

MOUISH, ARNOLD—graduate of hospital administration, Northwestern University will be assistant manager of the VA Hospital, Battle Creek, Michigan.

NICHOLS, WILLIAM S. See CAMPBELL notice.

OLIVER, DR. ROBERT K.—resigned as superintendent and medical director of the Montgomery Tuberculosis Sanatorium to accept a similar position with Hale Memorial Tuberculosis Hospital, Tuscaloosa, Alabama.

PAINTER, I. P.—new administrator of Monroeville Hospital, Monroeville, Alabama.

PARRISH, MORRIS H.—administrative resident of Memorial Hospital, Houston, Texas appointed administrative assistant. He is a graduate of the program in hospital administration, Northwestern University.

POWERS, DANIEL—appointed administrator of the Long Beach Memorial Hospital, Long Beach, Long Island.

PURDY, MRS. EARLE—named acting administrator of Blount Memorial Hospital, Oneonta, Alabama succeeding CARDEN M. ASTIN.

RIZZNER, JOSEPH S.—new assistant administrator of Passaic General Hospital, Passaic, New Jersey.

SINGLETON, EWELL—resigned as assistant administrator of the Methodist Hospital, Hattiesburg, Mississippi to enroll as a graduate student in hospital administration at Northwestern University.

SMITH, BILL C.—appointed administrator of the Fort Worth Children's Hospital, Fort Worth, Texas.

SPEARMAN, J. W. new administrator of Lamar County Hospital, Vernon, Alabama. He succeeds M. D. WOODS who had been acting administrator.

SISTER MARY STEPHEN. See SISTER MARY ESTHER notice.

STRAWBRIDGE, JOHN E.—appointed administrator of Maumee Valley Hospital, Toledo, Ohio.

SUMMERS, ROBERT S.—named administrator of the Miami Heart Institute, Miami Beach, Florida. He was formerly assistant administrator of Memorial Hospital of Chatham County, Savannah, Georgia.

THOGMARTIN, BRUCE M. See DAVIS notice.

TUCKER, JOHN G.—named assistant administrator and personnel director of Mobile Infirmary, Mobile, Alabama.

WALLACE, ROBERT E.—resigned as superintendent of Abilene State School, Abilene, Texas.

WETZEL, HAROLD E.—named administrator of Miners Hospital of Northern Cambria, Spangler, Pennsylvania.

WOODS, M. D. See SPEARMAN notice.

WRIGHT, DR. ROBERT DEAN—of Charlottesville, Virginia appointed assistant director for Health and Medical Activities of the Office of Vocational Rehabilitation, Washington, D. C.

Obituaries

MAXON, EVA W.—died in Boise, Idaho on August 12, 1959. She had been assistant administrator at St. Luke's Hospital in Boise since 1951 and personnel director since 1954.

STOREY, TONEY M.—administrator of Torbett Clinic and Hospital Marlin, Texas died suddenly on August 18, 1959.

Supplier's News

BELL, WILLIAM—will represent both the Institutional and Professional Divisions of Shampaine Industries. His territory includes the city of St. Louis and it's immediate suburbs, Southern Illinois, Western Kentucky and Southern Indiana.

FERGUSON, DON—appointed to Shampaine Industries Institutional Division sales staff. His territory will include Northwestern Indiana, Michigan's Southern Peninsula and the Northwestern section of Ohio.

FRIES, EDWARD—appointed president and general manager of the W. D. Allison Co., a Shampaine Industries subsidiary.

William Bell

Edward Fries

GILLERMAN, HARVEY M.—appointed director of research and development for Shampaine Industries, Inc. In this post, Mr. Gillerman will be in charge of all engineering research, product design and development and coordination of engineering personnel.

H. M. Gillerman

Dr. W. J. Haas

HAAS, DR. WARD J.—appointed director of operations for the Pfizer Laboratories Division and GEORGE C. MAYOUE, was appointed sales manager.

LOCKWOOD, ROBERT B.—appointed to represent the Shampaine Industries Professional Division sales staff. The companies he represents include W. D. Allison, Co., O.E.M. Corp., Professional Specialties, Inc., Shampaine Electric Co., and the Wilson Mfg. Co.

R. B. Lockwood

George H. Olsen

OLSEN, GEORGE H., JR.—appointed assistant to HARRY K. DEWITT, president of the Hospital Supply Division of American Hospital Supply Corp. Mr. Olsen was formerly sales manager of the Division's seven-state Chicago region.

PHILLIPPI, HAROLD G.—appointed sales manager of the seven-state Chicago region of American Hos-

pital Supply Corp's Hospital Supply Division. He was formerly sales manager of the Dallas region.

G. C. Mayoue

H. G. Philippi

PULSIFER, ROBERT H.—has been assigned to a sales territory in Nevada and Northern California, for Carrom Industries, Inc., Shampaine Co., and the Shampaine Electric Co.

R. H. Pulsifer

C. C. Rush

RUSH, CORT C.—will represent both the Institutional and Professional Divisions of Shampaine Industries in Washington, Oregon, Idaho and Montana.

SMITH, J. PHILIP—general manager of the Chemical Sales Division of Chas. Pfizer and Co., Inc., has been elected a vice president and will head Pfizer Laboratories.

W. H. Sumner

J. P. Smith

SUMNER, WILLIAM H. JR.—appointed manager of the Southwestern Sales Division for the Hospital Division of Johnson & Johnson. The division serves the hospitals of the entire Southwest.

TACY, A. C.—is the new manager of the Professional Sales Department directly in charge of all Hospital Dressings and Sutures for Bauer & Black, Division of the Kendall Co. Mr. Tacy is assuming the duties formerly handled by LOUIS H. NICHOLS, who retired on May 30, 1959.

A. C. Tacy

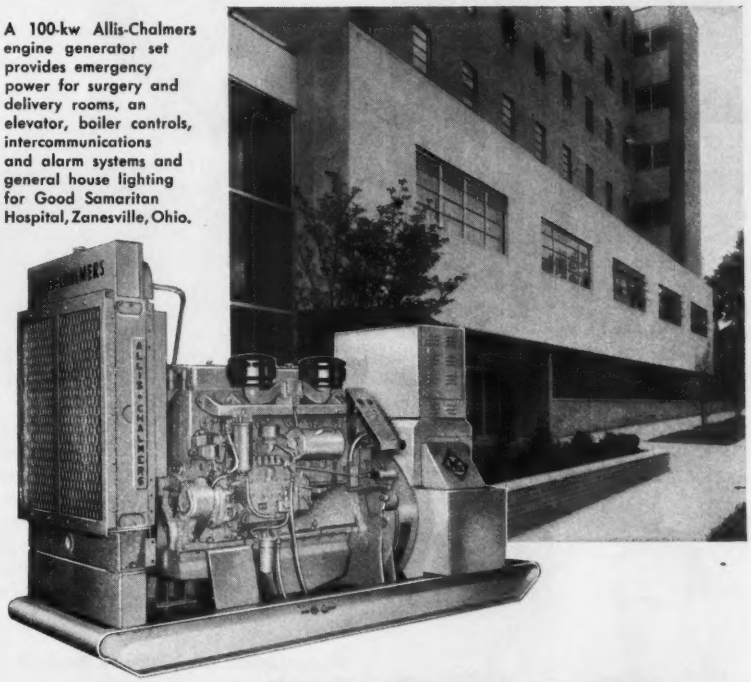
WALDECK, DR. W. F.—has joined Klenzade Products, Inc., as director of Research and Laboratories.

WILLNAN, JOHN N.—has been named vice president of the A. S. Aloe Company, St. Louis Missouri.

•

The real problem of your leisure is how to keep other people from using it.

A 100-kw Allis-Chalmers engine generator set provides emergency power for surgery and delivery rooms, an elevator, boiler controls, intercommunications and alarm systems and general house lighting for Good Samaritan Hospital, Zanesville, Ohio.



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BG-28

What Associations Are Doing

Mid-West Hospital Personnel Directors Association

C. C. Dade

Sr. M. A. Charles

■ THE FIRST large regional association of hospital personnel directors was formed June 27 at an organizational meeting held in St. Louis, Missouri. Primary objectives of the new "Mid-West Hospital Personnel Directors Association" are the development of effective personnel practices in hospitals, exchange of information on personnel policies and practices, and the encouragement of standardization in personnel methods and procedures.

C. A. Alsop

E. M. Barbarick

Officers elected were C. C. Dade, president; Sister M. Agnes Charles, vice-president; C. A. Alsop, treasurer; Edith M. Barbarick, recording secretary; and Louise M. Meadows, corresponding secretary. The officers will serve in an acting capacity until installed at an annual meeting to be held later this year.

The officers are all personnel directors in mid-west hospitals. Mr. Dade, who is also president of the Hospital Personnel Directors Association of Greater St. Louis, is with Barnes and Affiliated Hospitals. Sister M. Agnes Charles is with St. Mary's Hospital, St. Louis; Mr. Alsop is with St. Vincent's Hospital, St. Louis; Miss Barbarick is with St. John's Hospital, Springfield, Missouri; and Miss Meadows is with St. Joseph's Hospital, Kirkwood, Missouri.

L. M. Meadows

Membership is open to personnel representatives of hospitals, clinics, or other distinctly medical facilities, either as an active or associate member according to qualifications of the individual. Charter memberships will be granted to persons applying before December 31 of this year.

The new organization hopes to begin accomplishment of its objectives as soon as possible through bulletins and an official publication. Later plans call for workshops and seminars specifically relating to problems encountered by hospital personnel managers. ■

Association of Medical Record Consultants

■ The first annual meeting of the Association of Medical Record Consultants will be held January 21 and 22, 1960 in Chicago at the Morrison Hotel.

All sessions with the exception of the business meeting, on the morning of January 21, will be open to anyone interested in Medical Records.

The program will include such topics as, Consultation, Training and Services in the field of Medical Record Library Science. A registration fee of $5 will be charged to nonmembers of the association. A banquet with a nationally known speaker will be held in the evening of January 21.

Advanced registration may be made through: Grand Secretarial Services, 108 Grand Avenue West, Chicago, Illinois. ■

Academy of Hospital Counselors

■ THE Academy of Hospital Counselors met as a corporate body for the first time in New York City during the convention of the American Hospital Association. The following were elected as governors:

Term expires 1962: Alfred Maffly, Berkeley, California; Fred MacNamara, Washington, D. C.; Edward Thompson, M.D., Washington, D. C.

Term expires 1961: Tracy Hare, Miami, Florida; Louis Block, Ph.D., Washington, D. C.

Term expires 1960: John A. Steinle, New York City; Charles U. Letourneau, M.D., Chicago.

Elected to office for the forthcoming year were: Charles U. Letourneau, M.D., president; Louis Block, Ph.D., first vice president; John Steinle, second vice president; and Tracy Hare, secretary-treasurer.

Requirements for membership were approved and applications of qualified candidates will now be considered. ■

A.H.A. Distinguished Service Award

L to r: Ray M. Amberg, immediate past president of the Association and director of the University of Minnesota Hospitals presented the award to Dr. Edwin Crosby, vice president of the Association at the President's luncheon, during the AHA convention. Dr. Crosby was given the award for outstanding leadership in the field of hospital administration. ■

EVEN IN "SEEMINGLY HOPELESS CASES" INVOLVING "HOSPITAL STAPH"...

"It would appear, therefore, that from this limited experience with 17 desperately ill patients, parenteral novobiocin [Albamycin] is therapeutically effective and offers a reasonable expectation of a favorable response even in seemingly hopeless cases."

Garry, M. W.: Am. J. M. Sc. *236*:330 (Sept.) 1958.

"Staphylococcal sepsis, particularly as it appears within the hospital environment, continues to represent a serious and difficult therapeutic problem. . . . It would appear that novobiocin [Albamycin], like other broad-spectrum antimicrobial agents, will be of clinical value in a certain number of staphylococcal infections."

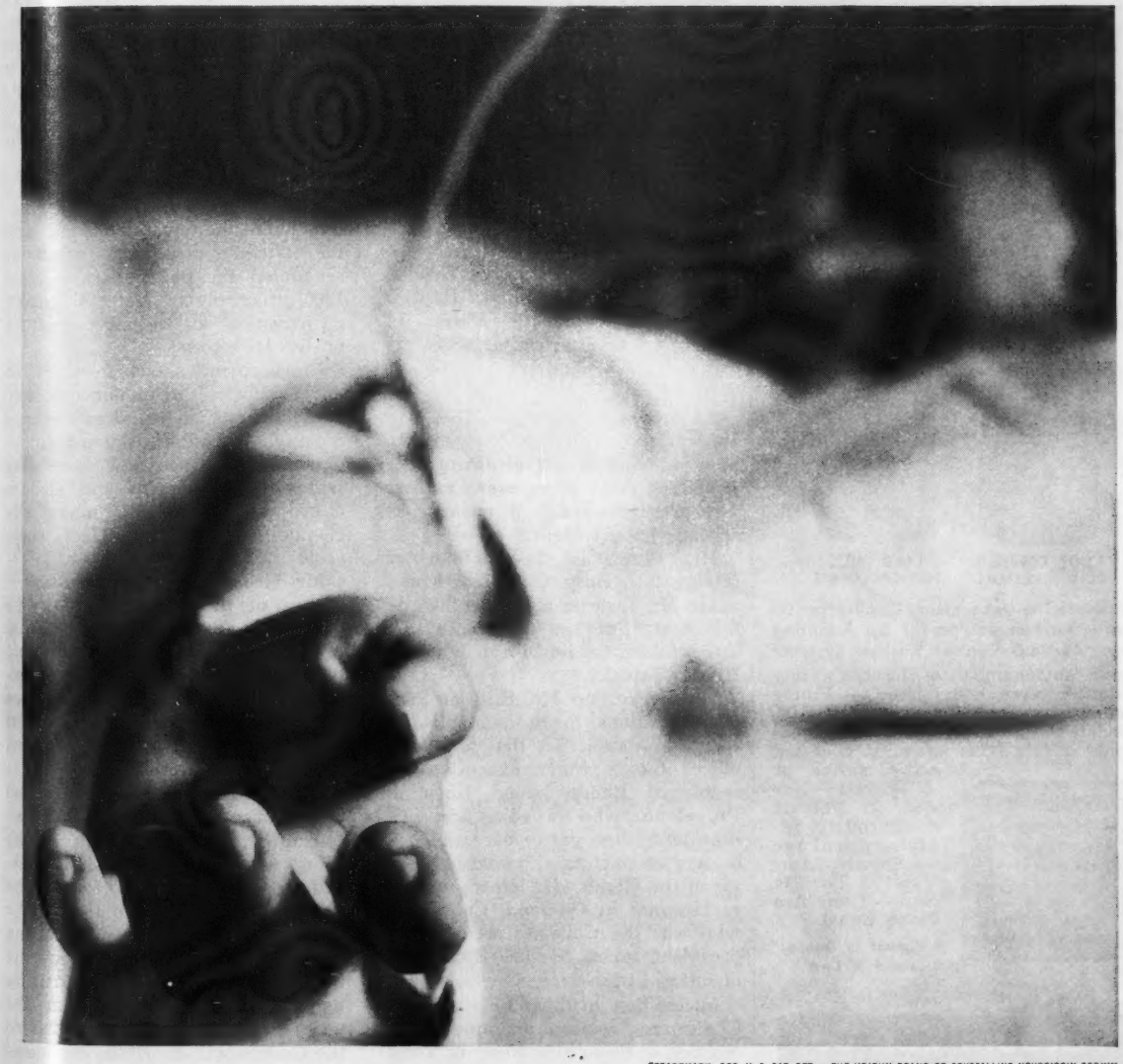
Colville, J. M.; Gale, H. H.; Cox, F., and Quinn, E. L.: Antibiotics Annual 1957-1958, p. 920.

The use of Albamycin has not been accompanied by systemic toxicity — renal, hepatic, or hematopoietic. Side effects (such as skin rash) have been minor in nature, and those that do occur are easily managed.[1-3]

1. Garry, M. W., *op. cit.* 2. Editorial, New England J. Med. *261*:152 (July 16) 1959. 3. Nunn, D. B., and Parker, E. F.: Am. Surgeon *24*:361 (May) 1958.

Upjohn THE UPJOHN COMPANY KALAMAZOO, MICHIGAN

ALBAMYCIN*



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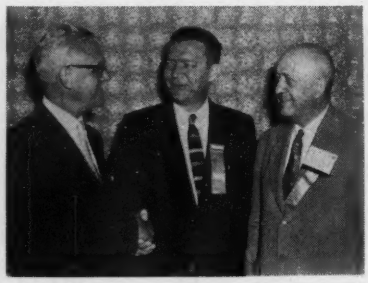
A.C.H.A. Activities

MELVIN L. SUTLEY, administrator of the Wills Eye Hospital in Philadelphia has been named president-elect of the American College of Hospital Administrators.

The announcement of his nomination to this office was made by A. J. SWANSON, former Regent, past president of the College and member of the Ontario Hospital Service's Commission, at the General Membership Assembly of the College in New York City. Mr. Swanson is chairman of the Nominating Committee.



Left to right: Anthony W. Eckert, immediate past president; Ray E. Brown, president; and Melvin L. Sutley, president-elect of the College.

At the same time, Mr. Swanson announced the election of two other new officers to serve during the 1959-1960 year: MARK BERKE as first vice president and S. A. RUSKJER as second vice president.

Mr. Berke is the director of Mount Zion Hospital in San Francisco; Mr. Ruskjer serves as the administrator of the Waverly Hills Tuberculosis Sanitarium in Waverly Hills, Kentucky.

Mr. Berke and Mr. Ruskjer take over positions made available by the termination of the terms of office of O. G. PRATT, executive director of Rhode Island Hospital, Providence, who served as first vice president this past year and DR. G. OTIS WHITECOTTON, medical director of the Highland-Alameda County Hospital in Oakland, California, who was the College's second vice president during the 1958-1959 term of office.

In addition to these new officers, Chairman Swanson announced the election of three new Regents. They are: RONALD D. YAW, Region 8 (Michigan); MAX B. WALLACE, Region 17 (Province of Ontario); and J. RALPH BOUTIN, M.D., Region 18 (Province of Quebec, Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland.)

Mr. Yaw, director of the Blodgett Memorial Hospital, Grand Rapids, Michigan takes over a vacancy created by the retirement from office of DR. ROBIN C. BUERKI, former president of the College and for many years a Regent. Dr. Buerki is executive director of the Henry Ford Hospital in Detroit.

Mr. Wallace, general superintendent of The Toronto Western Hospital in Toronto and Dr. Boutin, medical director of the Notre-Dame Hospital in Montreal, take over Regents' posts in areas previously combined as Region 17-18 and, for a period, supervised temporarily by A. J. Swanson of Toronto.

The College is making great progress with the compilation of data for its first directory, tentatively scheduled for publication early in 1960, according to FRANK S. GRONER, chairman of its special Committee on the Directory.

Biographical sketches based on data submitted by the membership are being mailed to all affiliates as quickly as possible to give them an opportunity to see how the listing will appear in print and also to afford the chance to make any changes that they might feel necessary.

Mr. Groner reported that the response of the membership of the College to the new directory has been exceptional. "Within the first two weeks after the initial questionnaire had been mailed, more than 2,000 had answered our request for information on their personal and professional lives."

His optimism was corroborated by WHEELER SAMMONS, JR., directory consultant, formerly with *Who's Who*, who said, "This is an unusually high response for a first mailing to a professional group."

The 1960 *Directory* will contain biographical data on all affiliates of the College. Tentative plans call for its publication every other year. The year the directory is not printed the College will distribute the membership *Roster*.

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—one reason why Ivory is by far the leading soap in hospitals everywhere!

There are 233 separate tests for mildness and purity that Ivory must pass before it is given the supreme test—baby's tender skin. Of course, Ivory has passed this test, too—and with highest marks—for more than 80 years. More doctors recommend Ivory than any other soap for both old and young patients. And today, Ivory has become the leading soap in hospitals everywhere. Its gentle lather cleanses thoroughly, yet is mild and refreshing even to the most delicate skin. Give Ivory a trial in your institution. It will quickly win your confidence, too!

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Soap

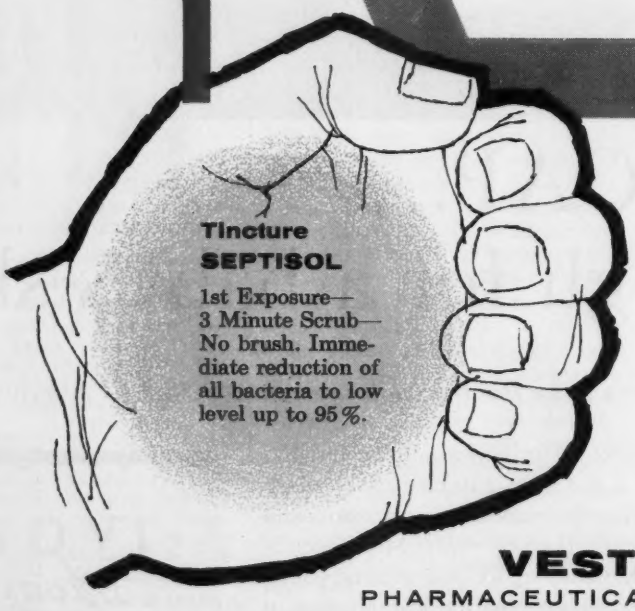
99⁴⁴/₁₀₀% pure® . . . it floats

New
SEPTISOL
3 dimensional procedure

provides quick effective skin degerming that lasts indefinitely without fear of skin irritation

High bacterial level on skin of person with no previous exposure to hexachlorophene washing, or whose exposure has lapsed for 24 hours or more.

1



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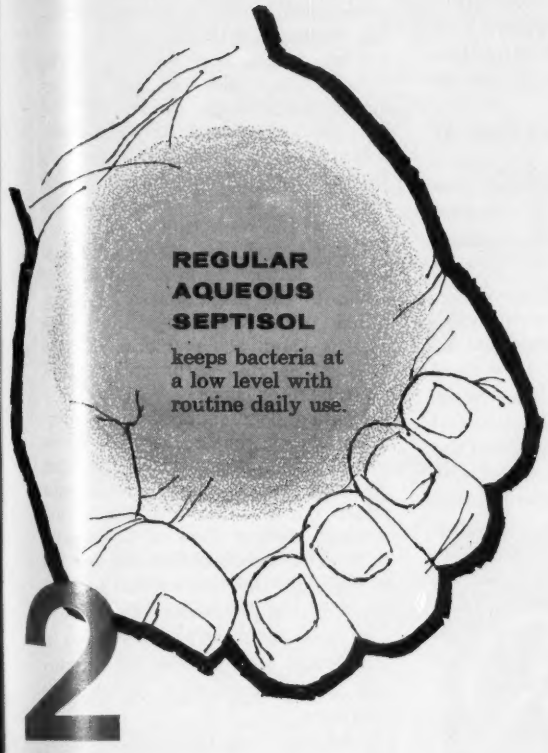


1st DIMENSION (Fast, effective skin degerming)

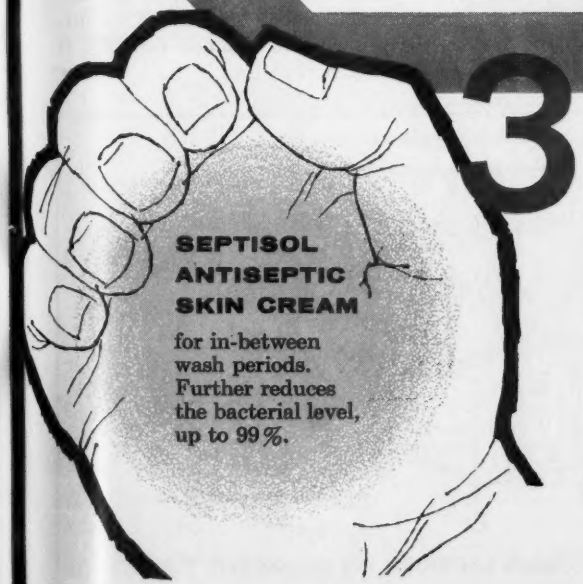
Tincture SEPTISOL (SEPTISOL diluted with 2 parts alcohol) combines the rapid killing power of alcohol, for immediate bacteria reduction, with the residual antibacterial activity of hexachlorophene, deposited in the deep layers of the skin to curb the regeneration of bacteria.

With Tincture SEPTISOL a person with no previous exposure to hexachlorophene may obtain, IN JUST 3 MINUTES OF SCRUBBING (no brush), a bacterial reduction otherwise attainable only in two or more consecutive days using an aqueous hexachlorophene detergent.

Tincture SEPTISOL is recommended for all emergency scrubs, all preoperative patient skin preparation, anyone with no previous exposure to hexachlorophene, whenever washing with hexachlorophene has lapsed for more than 24 hours.

2nd DIMENSION (Routine skin degerming)

REGULAR AQUEOUS SEPTISOL (SEPTISOL diluted with 2 parts water) gives effective residual antibacterial activity, high detergency cleansing action plus won't irritate normal skin. After the complete degerming of the skin has been accomplished by the 1st SEPTISOL Dimension, the routine daily use of REGULAR AQUEOUS SEPTISOL will build-up and maintain the hexachlorophene protection to curb the regrowth of disease causing skin bacteria. REGULAR AQUEOUS SEPTISOL is recommended for: the surgical scrub where there has been exposure to hexachlorophene within 24 hours. Scrub between glove changes, post-operative wash of surgical team and patient, and all regular hand washing by all personnel.



3rd DIMENSION (In-between wash periods)

SEPTISOL ANTISEPTIC SKIN CREAM:—Ideal for periods between washes, after hours, weekends, etc., to maintain the high degree of hexachlorophene protection. Keeps skin feeling fresh and clean. Adds additional hexachlorophene protection with each use. Prevents dryness and skin irritation. Excellent for infant skin lubrication and protection. Treats pyogenic skin infections. A wonderfully soothing massage to prevent patient bed sores.

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The Art of Ministering to the Sick

by Rabbi Arthur Brodey
Chaplain
Veterans Administration Center
Wood, Wisconsin

■ DO NOT BOUNCE into the room full of life and vigor, perhaps having just finished a game of golf, especially if the patient is seriously ill or crippled. Without being sad or plaintive, we should not be excessively cheerful. The patient knows how he feels.

Do not start telling jokes.

Do not rush in the room hurriedly, out of breath, as though anxious to get it over with.

Do not bring your own troubles or preoccupations to the patient by your very look of fatigue or sleepiness.

Do not enter if there is a sign posted, isolation or no visitors, unless directed by the nurse or doctor.

Do not be afraid of silence. That is really the toughest lesson of all to learn. The art of listening is the most difficult of all. Let the patient do the talking. That is the best therapy of all for the patient, if he really wants to talk. It is your presence that counts.

Do not repeat to anyone what the patient says, unless to the authorities if it is so required. Do not pry into the patient's affairs or personal life.

Make the patient feel he is the most important person in the world.

Do not suggest remedies or treatments, such as you read in this almanac or column that some new drug or treatment has been found.

Reassure the patient he will get well. Give him confidence in his doctors, nurses, and staff. If they gripe or get hostile to the hospital, remember some people love to gripe or complain. It is probably good for them. Don't take that pleasure away. If the occasion presents itself, you may say "I am sure they are trying to do the best they can."

Do not ask what is the matter with them or go over all their symptoms.

Do not talk religion or politics either. If the patient talks, listen.

If there is oxygen in the room make sure no one is smoking or all of you will go up in smoke. Do not smoke in the room or in the hallways.

Do not take beverages, foods, or medicines to the patient without permission.

Do not give your home address or telephone number to the patients even if you are single and he is a handsome bachelor. You are not there to make dates. He'll find out those details anyway if he wants to.

Every patient likes attention. If he asks you to do something such as hand him something, lift his pillow, do it. If you are in doubt, ask the nurse or attendant.

Do not bring him food from the coffee shop.

Do not forget the other patients in the room. Give them a word of greeting on entering or leaving.

One important rule is QUIET. This is too often neglected in hospitals today. The workers own voices in the room or hall should not be raised loudly, nor should they clack with their high heels. Silence heals. It keeps everyone calm. Doctors and nurses can work more efficiently. Noise is a shock to the nervous system, especially when patients bring in their radios and television sets. Remember the 23rd psalm "He leadeth me beside the still waters, he restoreth my soul." Quiet, calm, gentleness should be our motto. In the Talmud, written 1200 years ago or more, it says "Visit the sick for sympathy lightens the pain, fatigue him not by staying too long. Enter cheerfully for his heart and eyes are on those who come in." Make your visit brief and also never sit or lean on the bed.

On leaving the patient be sincere, wish him well. Hope he will feel better. Everything will be all right. Give him hope. Even if dying, never suggest the inevitability of death. ■

Excerpt from presentation to Tri-State Hospital Assembly Auxiliaries Section.

The History of The U. S. Army Medical Service Corps

■ The U. S. Army Medical Service Historical Unit in Washington, D. C., under the direction of The Surgeon General, is actively engaged in the preparation of the U. S. Army Medical Service Corps.

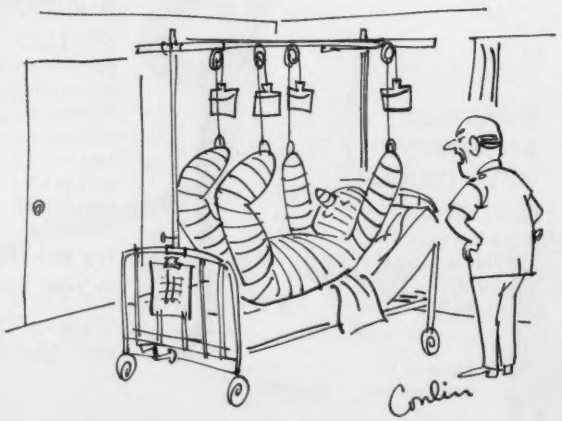
The introductory chapter of this volume will depict by historical example and analogy, the background that led to the establishment of the former Sanitary, Medical Administrative, and Pharmacy Corps as well as the present day Medical Service Corps within the Army Medical Department and the Army Medical Service. Other chapters will be devoted to the discussion of the detailed organization, administrative aspects, and achievements of the Medical Service Corps and each of its progenitor corps.

Military documents of all descriptions, records or articles of professional and scientific significance, personal letters, and photographs which relate to the activities of the present Medical Service Corps and each of its predecessors are needed to highlight this history and to augment official references.

It will be greatly appreciated if individuals who possess such material would forward it directly to:

Director
Historical Unit, USAMEDS
Forest Glen Section
Walter Reed Army Medical Center
Washington 12, D. C.

Any material forwarded to the Historical Unit will be returned to the owner after duplication of this material if that is his wish or the material will be retained and filed in the Historical Unit. ■



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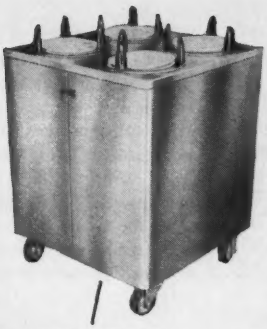

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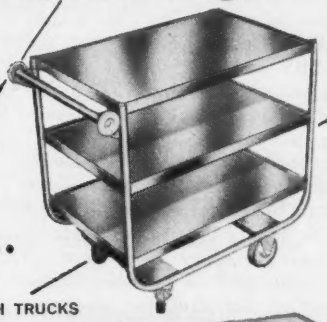

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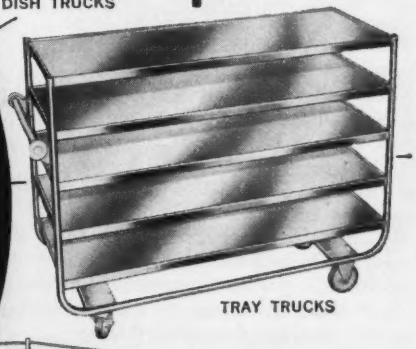
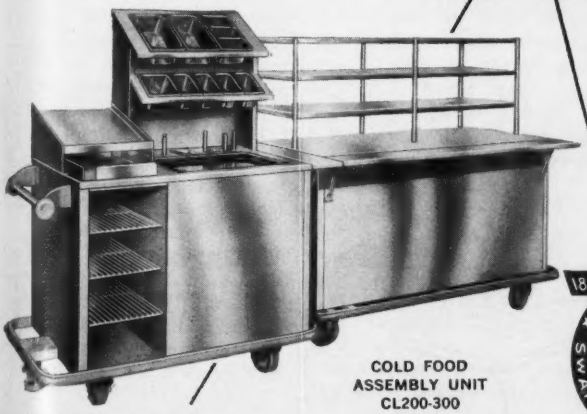


TRAY TRUCKS



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Continued from page 39

tice, will not only improve the health and well-being of the patients served but will achieve many economies."

In seeking care through physicians in group medical practice, labor wants to encourage desirable patterns of organization but has no desire or inclination to interfere in any way in the relationship between the doctor and his patient. In its study of direct service, closed panel plans, the A.M.A. Commission on Medical Care Plans encountered no instance of lay interference with professional judgment or action. President George Meany of the AFL-CIO had this to say of the physicians staffing the AFL Medical Center in Philadelphia, at dedication ceremonies in 1957:

"To such men, we are deeply grateful—and we can offer them in turn the assurance that labor respects their rights, their standards and their integrity. We have no urge to dictate or to control the practice of medicine, for we know that we are not competent to do so. We want only to help bring into being the kind of programs and facilities that will attract the best doctors and that will bring out the best that is in them."

The program sought for the worker is one that will provide coordination and continuity of medical care. This calls for easy access for consultation between the individual's personal physician and other medical specialists available in one facility. Carrying this further, the same physicians who serve the individual as a team in the group center, and when necessary in the patient's home, should also be able to serve the patient as a medical team when he requires hospitalization. Fulfillment of this goal is possible, of course, not alone through the provision of care by an organized medical group, but specifically by a group that is hospital-centered. Their aim has been voiced by Leonard Woodcock of the UAW in the following words:

"While the future of medical practice may be in a form that we cannot visualize today, it now appears that we should give very serious attention to possibilities of hospital-centered group practice. Prepayment, grafted on the existing structure of medicine, very likely will continue to be overpriced, inefficient, and may even support such harmful practice as unnecessary and excessive surgery. While Labor will continue to cooperate with the large fee-for-service free choice plans as a way to provide timely protection to most of its members, it is imperative that the deadlock be broken and that there be full and unimpeded development of group practice hospital-based plans. This is what our union is actively attempting to encourage today. This is what progressive hospital administrators should support."

As labor seeks improved patterns of health care, the emphasis is on merging its interests with those of the general community. David McDonald states:

"The United Steelworkers of America does not propose to separate itself from the problems of the community. We believe that the problem of providing and financing medical care is a responsibility of all elements in society."

The United Auto Workers takes a similar position, rather than taking what might be the easier course of building separate medical care programs just for the membership. Walter Reuther says:

"Setting up a Union program . . . would fragmentize medical care in the community and ultimately leave thousands and thousands of families in a kind of no man's land with no real protection. We support the community approach because we believe that labor in a free society cannot solve its problems in a vacuum—that we can make progress only if we cooperate with men and women of good will in the whole community to find answers for the problems of all the people."

The voice of labor, of course, is not a single voice, and it would be a grave error to attribute sweeping statements of philosophy to all segments of union leadership. Some unions are going it alone in developing medical care plans and may well continue on that course.

In general, one may sense a healthy lack of rigidity today as labor assesses its position in respect to health care. Most of those within the ranks of labor who have seriously studied medical care problems and adopted enlightened attitudes are not proceeding on the theory that any one approach can be considered a panacea nor that any one plan will be subject to democratic acceptance by all members of a union. Rather, they tend to think of arrangements that will allow the union member a choice of plan. Thus, those members who wish to continue patterns of care provided by solo practitioners may accept a plan of that nature and those who wish the more comprehensive coverage provided by group practice may select that type of coverage. In a speech given at the Tri-State Hospital Assembly this year, Leonard Woodcock stated:

"We in Labor believe in the merits of group practice, but we are inclined to see it developed in natural competition with other types of plans. This is why many of us are becoming increasingly committed to the principle of dual choice in which each individual is given an opportunity to select membership in a prepayment plan offering to pay any physician the patient wants, or one covering care by a closed-panel group. I think that rather than having entirely separate institutions in which group practice and solo practice each reign, as is the case in California, we are likely to see groups and solo practitioners working in the same hospitals in free and friendly competition."

This statement very aptly indicates the attitude of the United Auto Workers not only on the question of dual choice, but also on the question of integration with existing community facilities. Clearly union leaders want to work within the framework of existing community institutions wherever a permissive atmosphere can be found. However, as in the case of the United Mine Workers, or the group of AFL Unions in Philadelphia now planning to build a hospital, it seems quite clear that when adequate facilities are either not available or are closed to the type of care labor expects, labor will not hesitate to erect facilities that will bridge the need until community facilities are available and open to group practice physicians on a basis of equal status with solo practitioners.

I said, "We don't have much staph, not staff."

Part III in the December issue will conclude this study with the details of labor's interest in the group practice and prepayment. ■

Announcing

NEW RADIOLOGIC ADJUVANT
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Lavema (brand of oxyphenisatin) administered in an enema aids in prompt evacuation of gas and feces from the colon, thus ensuring a clear colon for roentgenography, proctosigmoidoscopy and surgery. Used in barium enema solution, it permits a more exact study of the mucosal pattern and function of the colon.

Uses

Cleansing Enema:

(1) Before abdominal roentgenographic examinations (flat plates, excretory urography, cholecystography, etc.) and examinations of the rectum, colon and sigmoid, (2) before roentgenography of the large intestine with a radiopaque enema and (3) for preoperative preparation of the large intestine.

Radiopaque Enema Adjuvant:

With barium enema suspension in (1) routine examination of the large intestine and (2) double air-contrast studies of the colon.

How Administered

Cleansing Enema:

½ to 1 packet (1.5 to 3 Gm.) thoroughly mixed in 1 to 2 quarts of water.

Radiopaque (barium) Enema:

½ to 1 packet (1.5 to 3 Gm.) well mixed in 1 to 2 quarts of barium enema suspension.

Clinical Experience

In a study of the use of Lavema in 355 cholecystographic cases at the Mayo Clinic, results were excellent in 303 patients and adequate in the remainder. In many of the latter, the fault lay in insufficient dosage of Lavema: ". . . the incidence of only partial cleansing was reduced to zero when the dose was corrected. . . . No side effects of any consequence have occurred from administration of the enema. . . . [Lavema] *has greatly reduced the incidence of re-examination and has saved time and expense for the patient.*"[1]

In a study of 223 patients at the Lahey Clinic, Lavema ". . . has been found to be very advantageous in a preliminary cleansing enema prior to air-contrast examination resulting in a high percentage of good and excellent air-contrast studies of the colon."[2]

How Supplied

Packets containing 0.02 Gm. Lavema in a lactose diluent q.s. ad 3 Gm., boxes of 100 packets.

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1. Donovan, Robert: The use of dihydroxyphenylisatin in cholecystography, *X-ray Technician* 30:84, Sept., 1958.
2. Salzman, F. A., and Wise, R. E.: Examination of the colon using a synthetic purgative, *Am. J. Digest. Dis.* 2:420, Aug., 1957.

Housekeeping

A Practical Program for the Housekeeper

The Control of Nosocomial Infections

by James C. McLean

Administrator
Fairlawn Hospital
Worcester, Massachusetts

■ WE ARE ALL walking incubators of bacteria. Just as one man's meat is another man's poison, many of us are carriers of organisms harmless to us but fatal to our neighbor. We need only witness epidemics of "childhood" diseases which wiped out the Indians in America, and the Eskimos of the Arctic who died by thousands of measles, whooping cough, and similar diseases. The ravages made in any primitive tribe when exposed to the white man's bacteria for the first time are a historical fact.

What do we do to control infection?

1. We keep bacteria from being transferred from one person to another.
2. We destroy bacteria that accumulate in various areas.
3. We keep the bacterial population down.

Break Chain of Infection

First we must realize that bacteria can attach themselves to any surface or carrier, live or otherwise. The basket of laundry, brought from a dirty basement or laundry truck, can carry to the immaculate operating room the bacteria from that basement or truck. The nurse, the porter, the dietary aide, the doctor (and unfortunately the doctors are not infrequently the biggest offenders) can carry infection from one patient to another, after handling the patient, his dressings, his diet tray or laundry.

Segregate, in a sense, each patient. Give him his own bedside utensils, bedpan, basin, mouthwash cup, urinal, thermometer. All these utensils can be sterilized at the time of the patient's discharge, before being used for another patient. The patient should have his own back lotion, his own tube of ointment or any other medication being applied periodically.

Hand washing should become a ritual. Before going from one patient to another the hands should be w a s h e d. Hexachlorophene soap, preferably liquid, should be used. Not only is there no chance of contamination from soap itself, if not in bar form, but there is little chance of people stealing liquid soap.

The basic idea should be, "Don't go from one patient to another without breaking the chain of infection." Dust and dirt harbor and protect bacteria. You can eliminate bacteria by eliminating dirt and, in eliminating dirt, let's not forget those out-of-sight places such as overhead beams and lights. We must give particular attention to air-conditioning machinery and the filters of these, because they frequently become spreaders of infection.

For the destruction of bacteria, there are a variety of weapons at our command. The disinfectants of the phenolic compounds (typical of these are O-Syl®, Amphyl®) are in my opinion the first and most effective weapons in our war on bacteria.

Recently there has been the development of combinations of disinfectant-detergents (Tergisyl®) which combine cleaning and sterilizing. The third category is the benzalkonium chlorides (Zephiran®). The first two groups of these are general purpose disinfectants for floors, walls, furniture and fixtures, toilets, laundering and, in some cases, for instruments and under special conditions for rubber and other materials. The benzalkonium chlorides are excellent for thermometers, catheters, instruments and items used on the patients, rubber goods, dishes, for douches, gargles, bladder lavage, wet dressings and irrigations.

We should make one note on disinfectants. The high pressure salesmen, agents for the "great new inventions," are out in force trying to ride the gravy train and get rich quick on the staphylococcus scare.

Buy Rated Disinfectants

Get ratings according to the United States Food and Drug Administration and Department of Agriculture Standard Methods, remembering that these need supplemental information. Find out if the product is effective against fungi and tuberculosis, and in what dilution. Ask the salesman what is in the product. If he does not know or will not tell you, WATCH OUT. Ask your administrator to subscribe

Presented at the Massachusetts Association of Hospital Housekeepers.

to the York Research Laboratories Service, at a cost of $18 annually. You can get many fine and impartial reports from them on products being presented for your consideration.

Use the Chemical Name

A further note on purchasing! Buy by the chemical name when possible. They are usually more economical. Do not be led astray by fancy smells. If something is clean, it has no odor, so you do not need any cover-up smells in your cleaner-disinfectants. Stay away from them. You can tell, also, if your employees are doing the job properly if you stay away from the highly scented products which cover up odors.

Watch out on brand names. Successful products are frequently imitated. Tergisyl® is already being imitated by a lemony-smelling mixture with a similar name and practically no value in killing organisms.

Discover Reservoir of Infection

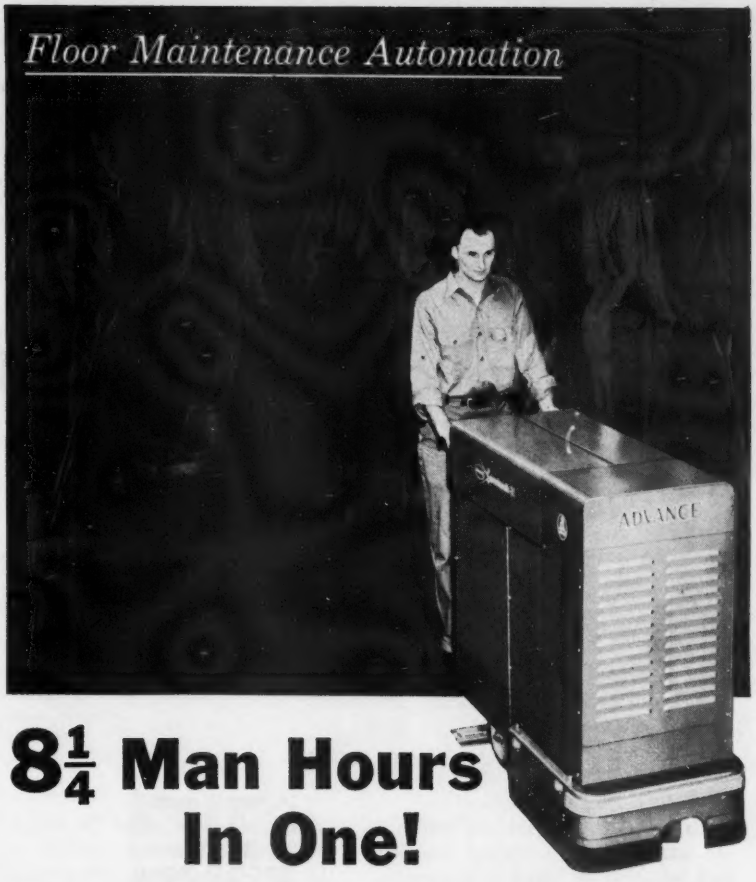
First, we have floors with dust, dirt, dried-on secretions. Gravity carries everything to the floor and we can't kick bacteria around until "they get lost." They don't. They pile up along the edges, the corners, along walls, around toilet fixtures, in utility closets and rooms and around examination tables. Dust protects them and screens them.

We need a good cleaner and a disinfectant to get rid of them. Dry sweeping and dust mops are taboo. Treated mops, or wet mops are acceptable under the right conditions.

Vacuum cleaners are fine if connected to a piped system or if the exhaust hose is vented to the outside, or if they are "wet pick-up machines"; otherwise stay away from them. If you have any arguments about this, tell your laboratory technician to expose a culture plate to the stream of exhaust air and when you get over the shock of seeing what grows on the plate, you will be convinced. The ideal floor cleaning system is a wet pick-up vacuum cleaner. Detergent disinfectant can be sloshed onto the floor and scrubbed by machine or mop, and the wet residue picked up by vacuum. A mop and pail technique is necessary if the vacuum equipment is lacking. Products like Tergisyl® loosen soil, kill bacteria and leave a bacteriocidal residue. That means it slows the bugs down and

Please turn to page 81

Floor Maintenance Automation



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Two Package Boilers

An investment with an annual return of 36 percent

by John E. Strawbridge, M.S.H.A.
Assistant Administrator
Riverside Hospital
Toledo, Ohio

and James H. Moss, M.S.H.A.
Administrator
Riverside Hospital
Toledo, Ohio

■ TWO PACKAGE BOILERS at Riverside Hospital in Toledo, Ohio, are earning an annual income of 36 percent on their investment. The total capital *(table 1)* investment was $40,659.79 (including interest on the three-year bank loan). Resulting "in-the-pocket" payroll savings are $14,704.75 per year. This "cost reducing" value is the only reason why two sturdy but stumbling coal-fired boilers were replaced in the autumn of 1957.

Other Values Accrued

Floor space of 1950 sq. ft. was opened for the maintenance shop. The compact boilers require little space compared with the old boilers and coal pile which used most of the 40 by 50 foot boiler room and 40 by 15 foot coal bin. On any basis of replacement cost, this badly needed space was worth at least $20,000.00.

An expense of almost $3,000 was avoided for pending repairs on old stokers and boilers.

Housekeeping is easier with the absence of occasional deposits of fly ash and soot from the smoke stack and frequent wind distribution of the ash pile.

Public relations in the neighborhood is improved considerably as the home owners now have to blame other factors for damage to new paint.

No Fireman

Payroll savings were made because firemen are not required to operate the new boilers. Ohio requires a licensed fireman in attendance at all times for any boiler having more than 360 square feet of heating surface. Because of improvements in boiler design and resultant high effiiciency, these boilers provide 125 horsepower from 358 square feet of heating surface, thereby being exempt from state requirements. Regardless of legal requirements, the old boilers functionally required the continual attendance of boiler operators. The new boilers operate dependably without them. Whether or not this is a safe practice has not been conclusively proven. However, in some areas, insurance underwriters will approve unattended operation of these boilers.

At Riverside hospital the firemen were notified of the impending plans and they were able to secure jobs even before the installation of the new boilers. Their salaries have been taken from the payroll and the savings therefrom are paying off the note which provided cash for this investment. The new boilers require some maintenance, but it is our experience that these costs will be much less than on the coal-fired boilers *(table 2)*.

The fuel cost per B.T.U. is greater for gas than for coal in this area, but the greater efficiency of these package boilers overcomes the increased unit costs so that the fuel expense before and after is essentially the same.

Prefabricated

For the benefit of the uninitiated, a package boiler is one which is prefabricated by the manufacturer and arrives at the site ready for immediate installation and operation. This is in contrast to a standard boiler, which is built on the site, from various components. Package boilers are remarkably efficient over a wide range of demand. The package boiler does not store steam in a reservoir which is maintained ready for use; rather it generates it spontaneously depending upon the demand.

Table 1. Total Capital Investment

Cost of boilers and return systems	$15,616.00
Installation cost — removal of old boilers, repiping, installation on new boilers	18,877.00
Total cost, labor and materials	$34,493.00
Interest expense on 3-year loan	3,093.00
	$37,586.00
Miscellaneous expense — upgrading of existing power plant equipment and piping not covered in installation per se - construction of a gas meter building, insulation, et cetera.	3,073.79
GRAND TOTAL	$40,659.79

It was June, 1957, when Riverside Hospital first reviewed the possibilities of replacing two coal-fired boilers with package units. After due consideration, two 125 horsepower gas-oil combination package units were purchased for immediate installation. The installation work was contracted with a competent heating and plumbing contractor via competitive bidding.

The first step was to contact the gas company for provision of fuel to the boiler room. Fortunately the parking lot beneath which the supply lines were to run had not been paved. The hospital erected a small building adjacent to the street to house gas regulators and meters. At this point the high pressure gas was reduced to four pounds and piped 85 feet under the lot to the boiler room. The pipe was laid in lime stone screenings and the trench was sand back-filled. The boiler room end terminated into a small, open gravel pit to provide escape for any leaking gas that would otherwise pocket beneath the lot. When the piping was completed and tested the parking lot was paved.

With gas service in, one boiler was put in service temporarily outside the boiler room. A light-weight galvanized iron shed was constructed to house it. The summer load was such that only the dietary, laundry and sterilizing units required steam and the single boiler proved more than adequate to carry the load.

Table 2. Owning Expense

Service and parts for two boilers since January 1, 1959 totals $195.90.

Fuel expenses for the first four months, January through April, 1959, in which there were 3,822 degree days were $9,264.73.

Removing Old Boilers

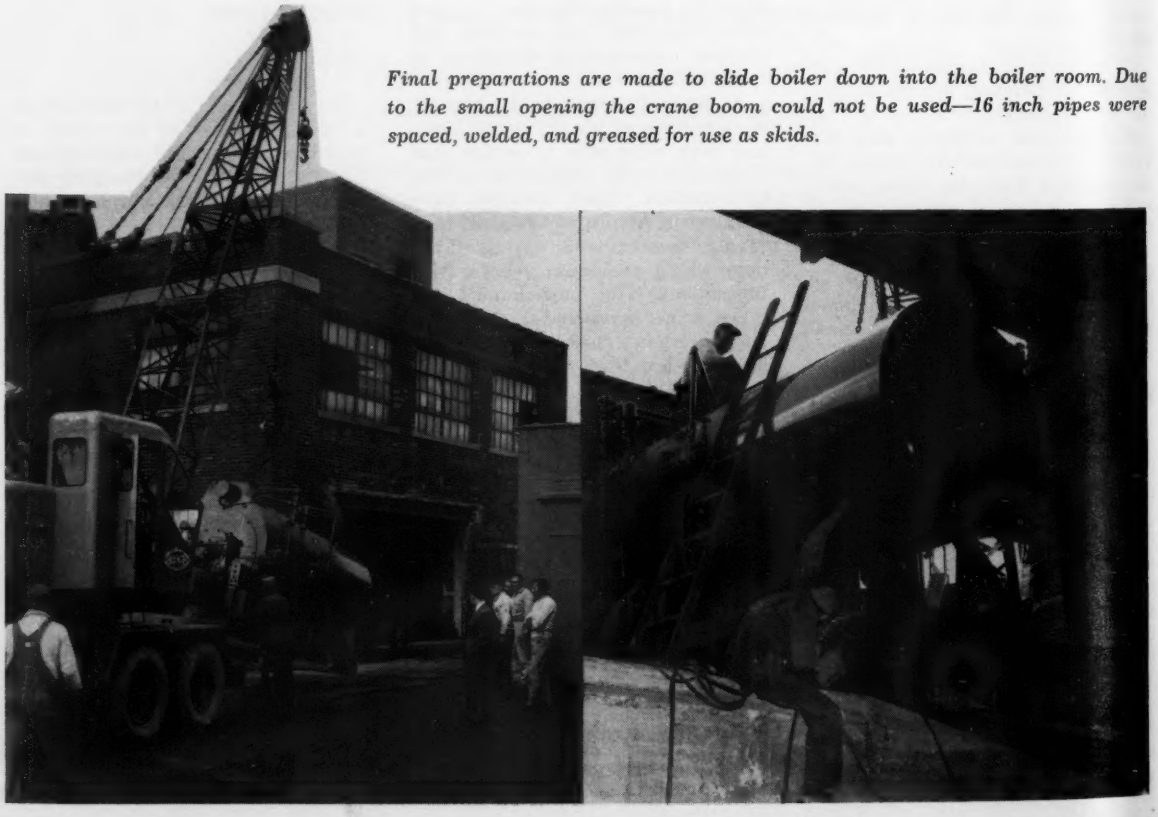
After several days of test run, work started on removal of the old boilers. This was the most difficult part of the job. Each was a huge 150 horsepower stoker-fed boiler of the fire-tube HRT variety. The boiler room floor is about 10 feet below grade, and all brick, mortar, iron, and other debris had to be hauled out in steel drums by a winch. This was an extremely dirty and time consuming operation which took roughly six weeks.

After the boiler room and coal bins had been cleaned out, the new pipe fitting and electrical wiring was started. At this point the second boiler was received and set in place in the boiler room. After all fittings were completed the No. 2 boiler was test run and put on the line. While it carried the load the first boiler was installed permanently in the boiler room.

When both boilers were running satisfactorily, the auxiliary fuel, No. 2 oil, was piped in and each boiler was tested on oil. Because of requirements of the gas company, a 2,000 gallon oil tank was used. This will operate the boilers for 24 hours at full capacity, during which time a fuel oil truck will be dispatched to keep the tank filled.

No Breakdowns

Due to fundamentally good design of the new boilers and the complete co-operation of the boiler service representative, the transition period was unmarred by breakdowns or lack of steam. Also, the need for service has been negligible. The only recurring trouble was caused by dirt and scale in old condensate return lines which plugged the feedwater pumps and this soon stopped. ■



Final preparations are made to slide boiler down into the boiler room. Due to the small opening the crane boom could not be used—16 inch pipes were spaced, welded, and greased for use as skids.

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BATTERY-POWERED SCRUBBER-VAC

in two sizes MARK 20 MARK 26

for quiet, efficient, continuous scrubbing

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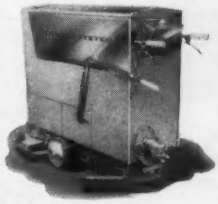
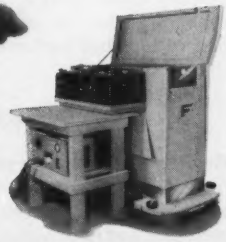


No switches to set for fast or slow — pressure of hand on clutch lever adjusts speed (up to 180 lineal fpm). Variable brush pressure to meet specific needs.



A compact battery charger is included with each unit as standard equipment. Batteries can be charged on the machine or rolled out on a charger bench.

For consultation or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 2711 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

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Food and Dietetics

Chicken — An Old Favorite with a New Look

■ THERE ARE probably few foods which have been served in greater volume over a period of centuries than chicken. Actually it is the only protein food, aside from fish, consumed generally around the world. However, the last few years have seen such changes in the chicken itself—packing, marketing, preparation and service—that the chicken doesn't seem to be the same bird at all.

This change has come about mainly because of the phenomenal progress made by the broiler industry in four major areas; genetics, nutrition, processing techniques and management know-how.

In the area of genetics through careful selection, breeders have developed a meat-type bird which is tender, fast cooking and has a high proportion of edible meat to the bone.

Nutrition-wise today's broiler chickens are fed a scientifically blended ration that contains at least 20 minerals and vitamins. The vitamins enable growers to raise birds indoors all year round making the "spring" chicken of former years obsolete. Energy producing ingredients promote the growth rate, with today's broiler-fryers growing to market maturity in nine weeks guaranteeing tenderness.

Ready to Cook

Mass production processing techniques, combined with high speed efficiency distribution methods, have made broilers available to all markets in a convenient ready-to-cook form. The processor has taken over the slaughtering and eviscerating service, eliminated waste completely and has obtained official government certification of the wholesomeness of his product. The processor offers his birds in a variety of ways—whole, halves, quarters, pieces, parts, pre-cooked and portion controlled—allowing wide latitude for economy, ease of preparation and menu versatility.

The broiler industry has today a production line operation made up of hatcheries, growers, feed dealers and processors, through whose combined efforts production costs are kept to a minimum.

Advantages to the Dietitian

The broiler-fryer is grown and processed under the highest of quality of standards, shipped to market when only nine weeks old, comes ready to cook, prepackaged in a variety of ways and is priced after the head, feet and viscera are removed. It is tender fibered, moist and succulent, fast cooking and has a high proportion of meat to the bone. Broiler-fryers are economical, highly nutritious, available the year round and are versatile beyond belief.

Low Cost

Labor cost is low because the chickens come ready to use and need a minimum of handling. The buyer orders them split, quartered and cut-up, according to use. The broilers can be ordered every day of the year in whatever "pack" style is preferred—all legs, all breasts, thighs, or legs. Since broiler-fryers are so tender comparatively short cooking time is needed. Also the majority of broiler fryers come ready-to-cook and, therefore, take far less refrigerator space than formerly necessary for dressed chickens. The fact that the price of poultry is relatively steady is another important aspect.

Portion Control and Ease of Preparation

Besides their low cost broilers are repeat items that can be prepared quickly and easily. The two-to-three-pound weight range offer the

Use Correct Terminology When You Order

Broiler or Broiler-Fryer — a young chicken, usually nine weeks old, of either sex, raised for meat purposes, tender-meated with soft, pliable, smooth-textured skin and flexible breast-bone cartilage, usually weighing between one and one-half and three and one-half pounds.

Bro-Hen — the laying hen of the broiler industry, about one and one-half years of age, weighing four and one-half to six pounds dressed, having a high ratio of meat to bone.

Capon — unsexed male chicken, weighing about four to seven pounds, tender and flavorful, with a large amount of white meat.

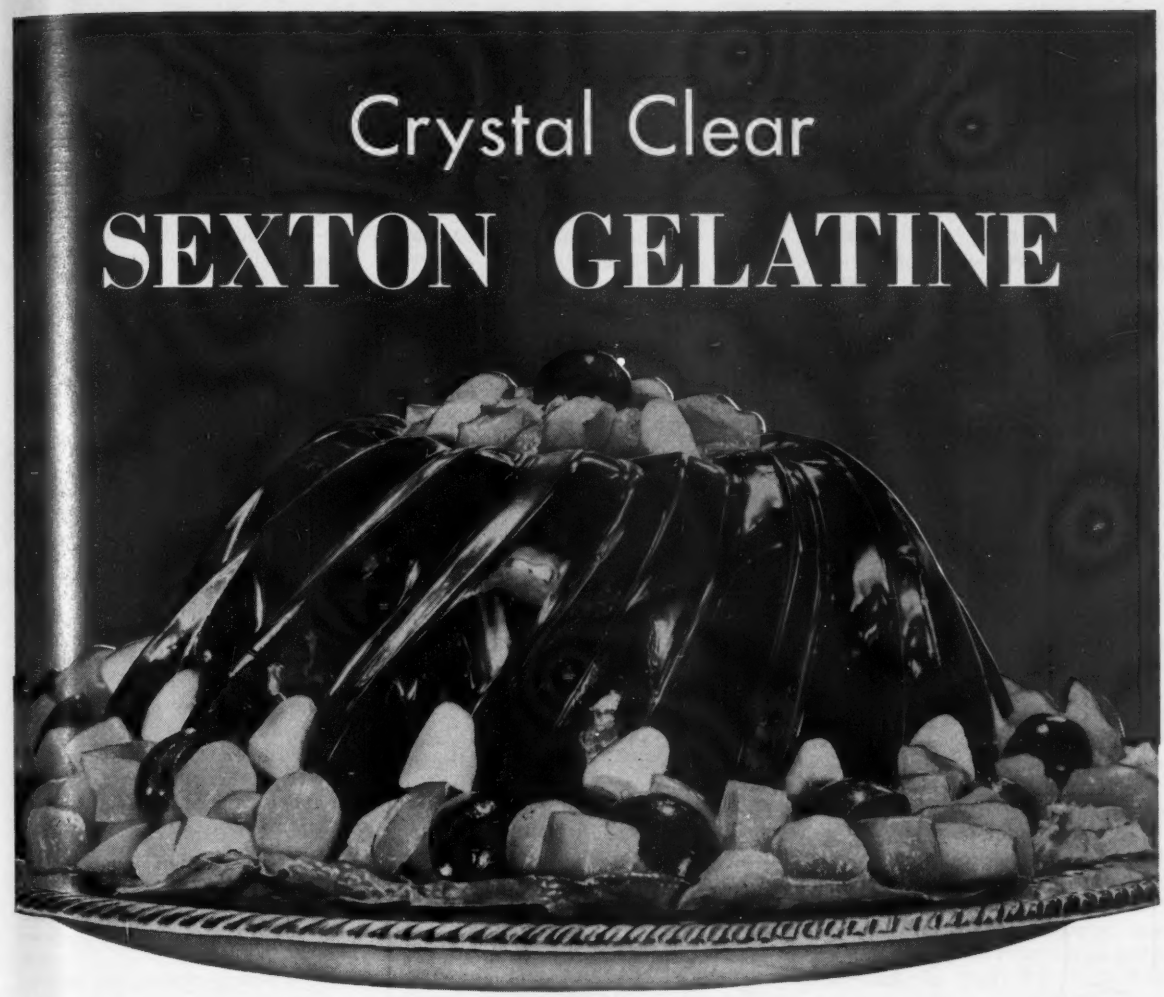
Fryer — the same as a broiler, but thought of in some areas as a slightly larger bird.

Hen — usually referred to as a stewing hen, laying hen from both broiler and egg-producing industries marketed when past ideal age for egg laying.

Ready-to-Cook — term which now applies to almost all commercially produced chickens, often called oven-ready, means pin feathers are removed, hair singed, bird thoroughly cleaned inside and out, giblets cleaned, wrapped and placed in body cavity, bird then shipped to market in iced wooden crates in refrigerated trucks.

Roaster — Tender chickens weighing from three and one-half to five pounds, now marketed at about 12 weeks of age.

Stewing Chicken — Currently popular term for a mature female chicken with meat less tender than that of a roaster.



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dietitian perfect portion control. Food cost of broiler-fryers is easily controlled because the buyer can choose the size chicken he wants within a one- or two-ounce range, or the exact size and parts he wants; for example, legs with a possible variation of a half ounce, and breasts within one ounce.

Chicken is exceptionally high in good quality protein, but for a high protein food, broilers are low in cholesteral count. Chicken also contains the important B vitamins, niacin and riboflavin. Darker meat is slightly richer in iron and in the various B vitamin than the white. Chicken livers are an important source of vitamin A.

Beyond broiling and frying, broiler-fryers present a wide menu potential. Baking, sauteeing, barbecuing, and braising are only a few of the methods with unlimited variations which can give menus a new look. Moreover within each category lies the limitless variation made possible by seasonings, sauces, wines and the like. (For some interesting chicken recipes see p. 84).

Chicken meat has always been an important source of healthful eating. Shorter fibered than most red meats, it is especially easy to cut and chew, making it ideal for children, invalids and elderly people. Its low fat content makes it easy to digest. Broilers are also lower in calories than other meat. Three and one-half ounces of raw boneless breast chicken contains only 104 calories.

Labor Saving Tips

Use commercial breading mixes, batter dips.

Dip chicken pieces in undiluted evaporated milk then corn flake crumbs for an adherent coating for oven-fired chicken.

Pre-mix seasonings, dredging mixtures; use seasoning salts.

Use canned soups, packaged white sauce base for sauces.

Use commercial stuffing mixes. Make these "your own" by addition of one or more simple ingredients such as chopped giblet or oysters.

Take advantage of biscuit, corn muffin mixes, pre-cooked rice, shelled almonds, canned cranberry, jellied red cherry sauce for accompaniments and garnishes.

Consider purchase of, then use to full advantage, pressure steamers and fryers. ■

To Add Savor To Chickens

Ac'cent — shake pure monosodium glutamate liberally over the flesh before cooking. Prepare a combination of one part ac'cent to seven parts salt and shake over fried chicken and French fries when serving.

French dressing — made with corn oil and exotic seasonings, used as a marinade and/or basting sauce.

Fresh Lemon and Lime Juice — used as basting liquid.

Fruits — such as cling peach, orange or pineapple slices added during baking or broiling; red cherry sauce baked in or spooned over.

Seasoning salts — use in kitchen and place on tables. Pre-mixed combination of salts, pepper, ac'cent and paprika used during cooking.

Spices — such as paprika, chili powder, poultry seasoning give extra zest, when added to breading mixtures.

Wines — in casserole preparation, and sauces.

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McLEAN

Continued from page 69

eventually, it kills them off. This one-shot performance of both cleaning and disinfection can save substantial labor costs with this type of cleaning; don't rinse. The residue that is left on the surface is effective against bacteria up to a week. Mops and buckets must be clean. Don't spread infection with dirty buckets and mops. Launder your mops at least daily. Have lots of mops and change after cleaning contaminated area. Put an automatic washing machine in the housekeeping department and do your own laundering of them.

Tergisyl®, in the proper dilution, can be used for walls, patient utensils, patients' rooms and other areas.

Linen and laundry represents one of the biggest hazards in spreading infection. The first advise is don't sort it; don't count it; don't mess around with it. It's dynamite! Get rid of it as quickly as possible. On any infection cases, the laundry should carefully and gently be put into bags in the patient's room so that it does not become a traveling spreader of infection on its way to the laundry.

Laundry chutes can become grossly contaminated. Use the spray heads which are located at the top of the laundry chute for washing down the chute. Use a detergent-disinfectant combination and rinse it with the spray head. I have been surprised in being in hospitals where the housekeepers thought that the spray heads were for putting out fires. If you look at the top of your laundry chute, you should find a sprinkler head there too, but the spray head is for washing down the chute.

As for laundry storage rooms, all I can do is shudder. The best advice is get your laundry into bags; get it out; don't let it sit around, particularly when wet. Blood and soil are ideal culture media. In many hospitals I've seen the spectacle of wet, soiled linen sitting around over the weekend, to use a graphic and descriptive phase, festering. Don't use the same containers for clean and soiled linen. Line clean linen baskets with a sheet, which can be returned to the laundry. Paper liners are alright but the disposal of them presents a fire hazard.

The standard laundering process for linens sterilizes them. The combination of detergents, hot liquids, bleaches, drying and ironing processes returns your linens to you free of bacteria. But make sure you do not contaminate your returned linens in the handling and distribution of them after they get back to your linen room.

Blankets are a great source of contamination, and this cannot be destroyed by the laundering methods used on wool. If the blankets are wool, use a disinfectant in the laundering process. This will cost you about eight cents per blanket and will give you effective disinfection; but why not get away from wool—use cotton.

Mattresses and mattress covers need consideration. A mattress cannot be "sterilized" by putting it out in the sunshine or air, even with a stiff wind blowing. Use a mattress cover that can be swabbed down with your detergent-disinfectant.

Regarding waste disposal, again the best advice is: don't handle the stuff. Use bags in your waste containers so that the garbage or rubbish can be taken out in a sack tied at the neck. Dressings should be discarded in paper bags at the bedside. Provide separate barrels for burnable trash and for nonburnable items, so that you can minimize the handling of infectious material by your employees.

Ice machines and water bottles frequently come within the province of the housekeeping department. The handling of ice introduces many elements of contamination and this routine should be surveyed. The ice machine should be washed thoroughly at frequent intervals, using a chlorine type disinfectant. Containers of ice must be of materials that withstand sterilization. The water bottles used at patients' bedside tables must be of materials that are washable in a standard washing machine, at a temperature of 180 degrees, and should be washed three times a day.

In all of these items, we run into the budgetary problem, but your administrator and trustees must realize that a sound program of good housekeeping and sanitation will be the most important and the least expensive step in infection control. The cost of antibiotics and malpractice insurance is going to be much higher than sanitation supplies and personnel.

The housekeeper must be strengthened. She must be a member of the Infections Committee of the hospital and have an active part in the total program. Know your responsibilities. Get good help; train them. Work on a program of keeping bacteria from traveling from one patient or area to another. Trace the chain of infection. Destroy the bacteria by effective cleaning methods. And, the final word I leave with you is *no disease producing organism yet found has developed a resistance to good housekeeping, cleanliness and sanitation.* ■

Let's Play It Safe

WRONG: Carelessness in moving heavy objects causes many disabling injuries.

RIGHT: Study the object to be moved and use equipment available to help you. Keep your fingers away from the areas which are dangerous.

Monthly Menus ★ Recipes on following page

	Sunday	Monday	Tuesday
Breakfast	**1** Casaba melon Hot cereal Grilled ham Danish coffee twist	**2** Prunicot Hot cereal Baked egg Toast	**3** Baked rhubarb Hot cereal 3-minute egg Raisin toast
Dinner	Roast turkey–giblet gravy Whipped potatoes Brussels sprouts Avocado–grapefruit salad Nesselrode ice cream	Braised short ribs of beef Hash brown potatoes Green beans, gascon Spinach–apple salad Loganberry cornstarch pudding	Cranberry–ham slice Mashed potatoes Frozen peas Tossed salad greens Apple tart
Supper	Cream of spinach soup Chili–cheese bun Golden glow salad Tokay grapes Sugar cookies	Consomme Smothered liver Escalloped potatoes Tomato–endive salad Fruit cocktail	Cream of crecy soup Savory meat loaf Stuffed baked potato Krispy relishes Fruit bars
Breakfast	**8** Grapefruit half Hot cereal Scrapple Sweet rolls	**9** Fruit nectar Hot cereal 3-minute egg Toast	**10** Kadota figs Hot cereal Scrambled eggs Toast
Dinner	Blended fruit juice Veal birds–gravy Glazed sweet potatoes Julienne carrots Pickle relish salad Strawberry ice cream	Yankee pot roast Browned potatoes Diced turnips Endive–radish salad Rhubarb brown betty–lemon sauce	Salisbury steak Parslied potatoes Braised celery Pineapple–cherry salad Chocolate–whipped cream cake
Supper	Vegetable soup Canadian bacon Ravioli Frozen fruit salad Almond macaroons	Potato–celery soup Grilled sweetbreads with bacon Lima beans Tomato–lettuce salad Whole peeled apricots	Pepper pot Roast tenderloin of pork Chantilly potatoes Tossed mixed salad Escalloped apples
Breakfast	**15** Grapefruit half Hot cereal Crisp bacon Kolaci	**16** Bananas–cream Cold cereal Scrambled eggs Toast	**17** Orange juice Hot cereal Poached egg Raisin toast
Dinner	Chilled fruit ★ Oven baked chicken Steamed rice Broccoli–hollandaise sauce Olives–relishes Oriental ice cream sundae	Liver bernaise Potato cakes Julienne celery and green beans Lettuce wedge–herb dressing Cabinet pudding	Fillet of lamb Mashed potatoes Pimiento cauliflower Grape–melon ball salad Chocolate floating island
Supper	Corn chowder Cheese rarebit on toast Fruit salad Peanut brittle Bavarian cream	Tomato bisque Cubed steak sandwich Cottage potatoes Cole slaw Orange–coconut gingerbread	Vegetable soup Frankfurter casserole Tomato–cottage cheese salad Melba peach
Breakfast	**22** Tangerine Hot cereal Scrambled eggs Toast	**23** Blue plums Hot cereal Baked egg Toast	**24** Grapefruit half Hot cereal 3-minute egg Toast
Dinner	Roast fresh ham Glazed sweet potatoes Brussels sprouts Cinnamon apple ring salad Vanilla ice cream	Veal scallopine Potato puff Wax beans Beet relish salad Peach betty	Beef a la mode Golden brown potatoes Fresh spinach mounds Peach–cherry salad Brownies
Supper	Julienne soup Chicken hash in noodle nest Red and green salad Assorted fresh fruit Meringue balls	Chicken chowder Canadian bacon Corn a la southern Tossed salad greens Cubed gelatine–custard sauce	Potato–carrot soup Ham timbales Lima beans Cornbread sticks Shredded lettuce Baked apple
Breakfast	**29** Orange slices Hot cereal Crisp bacon Black walnut coffee cake	**30** Raisin sauce Hot cereal 3-minute egg Toast	
Dinner	Veal steak, hungarian Roast potato balls Frozen peas Stuffed dill pickle salad Maple mousse	Minted roast leg of lamb Franconia potatoes Harvard beets Chef's salad Orange slices–custard sauce	
Supper	Minestrone Turkey a la king on toast points Hominy cakes Endive–tomato salad Cranberry whip	Tomato–celery soup Corned beef pattie Egg plant Shredded lettuce Molasses mint pie	

November 1959

Wednesday	Thursday	Friday	Saturday
4 Sliced oranges Hot cereal Bacon curls Pecan rolls ● ★ Golden chicken el dorado Baked squash Health salad Candied fruit ice cream sundae ● Potato chowder Hot roast beef sandwich Creamed onions Pickled peach salad Gold cake–caramel icing	**5** Apple sauce Hot cereal Scrambled eggs Toast ● Swiss steak Chantilly potatoes Broccoli Bing cherry salad Snow pudding ● Carrot–celery soup Veal paprika with dumplings Broiled tomato half Lettuce wedge–french dressing Date torte	**6** Grapefruit half Hot cereal Omelet Toast ● Tenderloin of trout–tartar sauce Crumb potatoes Spinach a la swiss Mexican salad Cherry roll ● Jungle soup Crabmeat mornay Potatoes, julienne Cauliffoweret salad Sponge cake a la mode	**7** Tomato juice Hot cereal Shirred egg Toast ● Hot spiced tongue–mustard sauce Delmonico potatoes Carrots and peas Corn relish salad Mincemeat cobbler ● Bouillon Sirloin tips–bordelaise sauce Paprika potatoes Marinated cucumbers Hot fruit compote
11 Orange segments Hot cereal Sausage squares Butterscotch biscuits –jelly ● Broiled veal chop Duchess potatoes Pickled beets Carrot–raisin salad Vienna tart ● Consomme julienne Chicken pot pie Noodles Lettuce–russian dressing Hermits	**12** Blue plums Hot cereal Omelet Toast ● Roast virginia ham–cider sauce Mashed potatoes Hot slaw Fig–waldorf salad Raspberry sherbet ● Lentil soup Broiled lamb pattie Baked potato Asparagus–pimiento salad Banana cream cake	**13** Pineapple juice Hot cereal Baked egg Toast ● Baked halibut–egg sauce Watercress potatoes Wax beans Fiesta salad Candied broiled grapefruit half ● Oyster stew Egg salad sandwiches Potato flakes Vegetable jackstraws Cake top lemon pie	**14** Stewed apricots Hot cereal 3-minute egg Cinnamon toast ● Roast loin of pork apple sauce O'Brion potatoes Blackeyed peas Julienne vegetable salad Blueberry pinwheel–vanilla sauce ● Alphabet soup Hamburger–bun Hot potato salad Indian relish Baked pear
18 Cinnamon prunes Hot cereal 3-minute egg Toast ● Stuffed roast shoulder of veal Lima beans Grated beets Lettuce toss Royal anne cherries Ginger snaps ● Scotch broth Sausage pattie Escalloped potatoes Mexican salad Apple dumpling–foamy sauce	**19** Fruit nectar Hot cereal Crisp bacon Pecan coffee cake ● Swedish meat balls with mushrooms Whipped potatoes Creamy corn Rosy pear salad Graham cracker pudding ● Mulligatawny soup Cold sliced beef Macaroni au gratin Hot rolls–jelly Salad macedoine Fig filled cookies	**20** Apple sauce Hot cereal Shirred egg Toast ● Perch fillet–tartar sauce Creamed diced potatoes Peas Endive–tomato salad Tri–fruit sherbet ● Mock bisque Tuna newburg Broccoli Lettuce wedge–1000 island dressing Strawberry cobbler	**21** Casaba melon Hot cereal Link sausage Swedish rolls ● Stuffed flank steak roll Latticed potatoes Escalloped egg plant Normandy salad Iced cookies ● Bouillon Chicken upside–down pie Mashed potatoes Baked squash A-B-C salad Caramel pudding
25 Bananas–cream Cold cereal Poached egg Toast ● Country fried steak Lyonnaise potatoes Carrots in cream Piccalilli Blackberry cake ● Hot vegetable juice cocktail Casserole of lamb with mashed potato topping Red cabbage salad Fruited vanilla pudding	**26** Pineapple wedges with grapes Hot cereal Link sausage Peanut–orange rolls ● Spiced cider punch Watermelon pickles–celery en branche–stuffed olives Glazed roast turkey Delicious sweet potatoes Frozen asparagus ● French onion soup Ham–cheese sandwiches Shoestring potatoes Fruit salad Turkey centered ice cream Horn of plenty cookies	**27** Kadota figs Hot cereal Scrambled eggs Raisin toast ● Mackerel–spanish style Parslied cubed potatoes Breaded tomatoes Tossed green salad Iced gingerbread ● Fish chowder Stuffed deviled eggs–cheese slice Kidney bean salad Blueberry muffins–jam Frosted fruit cocktail	**28** Apricot nectar Hot cereal Shirred egg Toast ● Beef–kidney ragout Stuffed baked potato Fresh spinach Peach bloom salad Crumb cake ● Turkey–rice soup Grilled pork chop Mashed potatoes Fiesta salad Apple pan dowdy

Plentiful Foods MONTHLY LIST

Pork Turkeys Broilers and fryers

Potatoes Sweet potatoes Onions Rice

Almonds Cranberries Lard Apples Filberts

Golden Chicken el Dorado

Selected Recipes From Preceding Menus

Golden Chicken El Dorado	12 servings
Ingredients	Measure
Broiler-fryer chickens	3 2½ to 3 lb.
Corn flakes or	4 qt
corn flake crumbs	1 qt
Butter	¾ c
Chopped onion	¾ c
Diced celery	1½ c
Stock or water	¾ c
Salt	¾ tsp
Poultry seasoning	1½ tsp
Canned cling peach slices	24

Cut chicken into quarters; if cornflakes are used, roll into crumbs.

Melt butter; add onion and celery; cook until tender but not brown; add stock, salt and poultry seasoning; bring to a boil; remove from heat; add crumbs and toss lightly.

Line baking pans with heavy duty aluminum foil.

Turn in stuffing; top with chicken quarters; brush quarters with additional melted butter; bring ends of foil together over chicken; make double fold; make double fold at each end.

Bake in a hot oven (450°) 40 min.

Open foil push stuffing to one side; place drained peaches, cut side up on foil;* roast 20 min longer to brown chicken and heat peaches.

*If desired, peaches may be placed in separate pans and baked.

Oven Baked Chicken	24 servings
Ingredients	Measure
Broilers, split	12 (2½ lb)
Monosodium glutamate	
Salad oil or rendered chicken fat	3 c
Salt	1/3 c
Pepper	1½ tsp
Paprika	1/3 c

Place chicken* skin side down in baking pans; sprinkle with monosodium glutamate; let stand 20 min., if possible.

Salt and pepper chicken; turn chicken.

Make a basting mixture of oil, salt, pepper and paprika; baste skin of chicken; cover and bake at 350° for 1 hour.

Uncover; baste; bake uncovered 30 mins.

*To serve stuffed: Grease baking pan; spread with your favorite stuffing evenly; place the broiler halves on stuffing; bake as directed.

Vary basic baked chicken by basting with herb-flavored butter or highly seasoned tomato sauce, baking for the last half hour in sour cream.

Note: For maximum flavor retention prepare baked chicken so that preparation coincides with the peak serving load then hold at 150°.

Oven Broiled Chicken

Place split chicken skin side down on sheet pan; brush with seasoned fat and broil about 4 inches from flame for 6 or 7 minutes, then turn and broil 6 or 7 minutes longer.

Finish off by baking in the oven about 45 min.

Baste with seasoned fat once or twice during the baking.

Oven Fried Chicken

Bread chicken, fry until partially done, then finish off in the oven. Results in a higher percentage of thoroughly-cooked chicken and reduces the handling and watching necessary.

Oven Barbecued Chicken

Barbecuing chicken is just one step up from broiling. The chickens are frequently basted with a favorite recipe or commercial barbecue sauce, some of the sauce being poured over at serving time.

Some prefer the flavor if the chicken is first marinated in the sauce, then basted with more of it during cooking.

Tomato Barbecue Sauce	1 qt
Ingredients	Measure
Dry mustard	1 tbsp
Brown sugar or unsulphured molasses	3 tbsp
Salt	1 tbsp
Monosodium glutamate	1 tsp
Vinegar	¾ c
Water	1 c
Catchup	1½ c
Tabasco	1 tsp
Corn oil	4 oz
Onions, chopped	3 medium
Garlic, minced (optional)	2 cloves

In a saucepan mix mustard, sugar and salt; stir in vinegar, water, catchup and tabasco; add oil, onion and garlic; bring to a boil; simmer 15 min.

Use as a basting sauce. ■

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Editor's Note: Here is the first half of a fine article illustrating another of the many areas where hospital pharmacy can be of valuable service in contemporary hospital care. While it is aimed at hospitals that specialize in the treatment of mentally retarded and related patients, it by no means should be restricted to such specialized hospitals. Hospital personnel in all areas will find value in this article. DFM

Pharmaceutical Procedures

In the Pharmacy of a Hospital School

by Kenneth E. Tiemann and Dr. Frederick V. Lofren

■ IN THE SEARCH for new fields into which to introduce hospital pharmacy practice, an area was discovered where pharmacy could play an important role in maintaining the health and strength of a group of people who are often overlooked in our fast-moving, progressive society. This group, who need help to lead normal useful lives, are the mentally retarded and, in this specific case, exceptional children.

This new area is illustrated in a private school and hospital for exceptional children, The Brown Schools of Austin and San Marcos, Texas, which were founded on a belief in the exceptional child himself. The objective of the schools is a three-fold one: (*a*) to develop and educate those students who have the potential capacity to resume a normal existence in our society; (*b*) to train those students who have the potential to return to society under sheltered conditions; and (*c*) to provide continuous care for those children who must live in a protected environment.[1]

Each unit of the school has nurses on duty 24 hours daily. Although most of the children are ambulatory and attend classes, some are confined to beds or chairs and require constant care.

This school may definitely be classified as a hospital since medical care is required by all the children at least part of every day. Doctors, nurses, psychologists and other medical personnel are in constant attendance and practically all hospital services are rendered. Also, of the approximately 400 children in this institution, about 90 per cent are administered medications regularly, such as tranquilizers, antispasmodics, sedatives, hypnotics and antibiotics.

Organizational Structure and Relationships

Organizational structure strives to create an atmosphere in which friction is minimized and men's energies are released in productive and satisfying effort. The various attempts to create effective organizational structure have resulted in three distinct types, namely, *line organization, functional organization and line-and-staff organization.*[2]

With the exception of most smaller organizations, where it is possible for personal intimacy to exist in high degree, the line-and-staff organization is favored by most companies. Even where no conscious thought has been given to problems of organization, it is usually the line-and-staff type of organization that is used.[3]

Most hospitals have adopted the line-and-staff type organization, and so it is with The Brown Schools.[4]

Realizing the importance of medication to the students of The Brown Schools and recognizing the inadequacy of the hospital's current methods of dispensing drugs, the Board of Directors decided to establish a pharmacy within its organization. With this in mind, advice and counsel were sought from a registered pharmacist. This ultimately resulted in the establishment of the pharmacy of The Brown Schools on a trial basis on July 1, 1958.

The pharmacist, as a staff executive to both the coordinator of professional activities and the comptroller, acts in several capacities.

Please turn to page 93

From The University of Texas, College of Pharmacy, Austin.

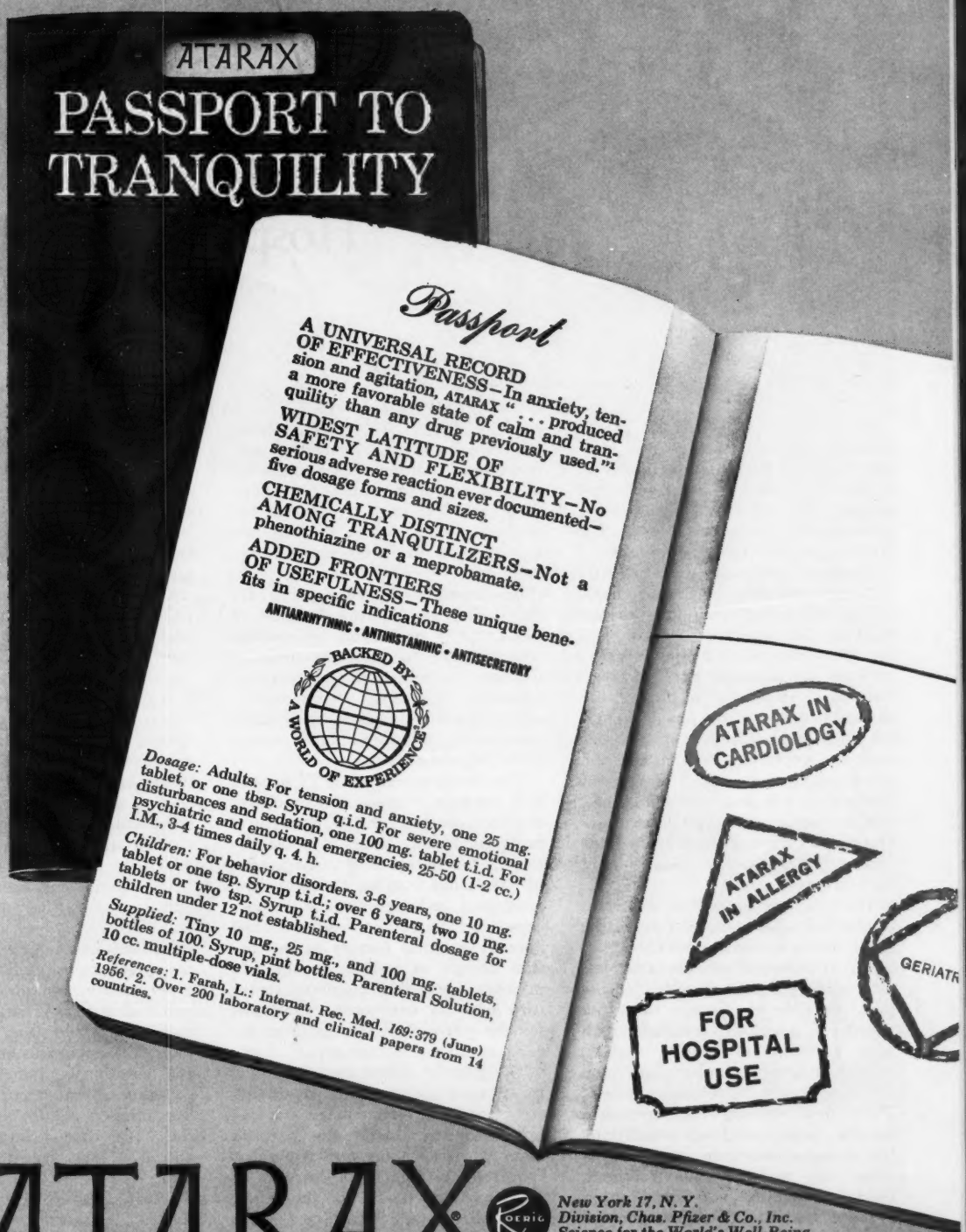
Abstrated from a thesis submitted by Kenneth E. Tiemann to the graduate school, The University of Texas, in partial fulfillment of the requirements for the degree of Master of Science in Pharmacy.

[1]The Brown Schools Manual, September 1, 1957, Section 3, page 1.

[2]Spriegel, William Robert; Schulz, Edward; and Spriegel, William B.: Elements of supervision. New York: John Wiley and Sons, Inc., 2nd ed. p. 23.

[3]Scott, W. D.; Clothier, Robert C.; and Spriegel, William R.: Personnel management. New York: McGraw-Hill Book Company, Inc., 4th ed. p. 30-33.

[4]The Brown Schools Manual, September 1, 1957, Section 501, p. 1-1a.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Dosage: Adults. For tension and anxiety, one 25 mg. tablet, or one tbsp. Syrup q.i.d. For severe emotional disturbances and sedation, one 100 mg. tablet t.i.d. For psychiatric and emotional emergencies, 25-50 (1-2 cc.) I.M., 3-4 times daily q. 4. h.
Children: For behavior disorders. 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d. Parenteral dosage for children under 12 not established.
Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.
References: 1. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956. 2. Over 200 laboratory and clinical papers from 14 countries.
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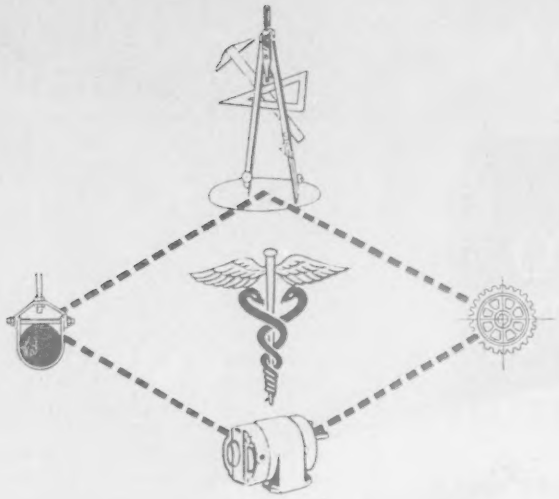

by Daniel M. Roop, P.E.

An Emblem of Hospital Engineering

■ WITH THE INCREASED COST of hospital design, construction, and operations, the role of the hospital engineer, and the interest in his professional responsibilities and training, has become paramount.

Hospital administrators, architects, and design engineers are finding it necessary to delve into the field of ever changing functions and the importance of adequate engineering management skills. This is necessary, not only to protect the dollars invested in the physical plant facilities and equipment, but to assure the governing boards, and the community, that a high degree of medical care is available at all times, and to assist the hospital administrators in carrying out the functions and responsibilities of their patient care program.

The engineering skills and role of the individual responsible for the continuance of the patient care program in this professional area has also changed dramatically in the past decade. No longer are the country's hospitals designed with only a simplified heating system, plumbing system, boiler plant, and an elementary electrical system. They now include high pressure boilers, year-round air conditioning systems, intricate control systems for adequate environment, electrical supply and distribution systems that are more complicated than an average municipal system; electronic devices of all types and descriptions for medical, surgical, psychiatric and nursing care; increased plumbing facilities encompassing oxygen, vacuum, and air pressure systems, sterilizing and processing equipment, and many more major classifications of equipment and building components requiring a high degree of skill and management for their preservation and use.

In order to describe pictorially the varied and multiple aspects of this growing profession, an emblem was designed to show the fields of endeavor in which the professional engineer, graduate engineer, or maintenance superintendent must collectively or individually accept their responsibilities.

The drawing compass, "T" square, and triangle represent symbols of the engineering and architectural professions and their responsibilities in the design and management of functional hospital facilities. The analytical and technical skills possessed by the professionally trained person are vital factors in the initial design, as well as in the administration of the completed structure and its occupants, developed for the purpose of providing medical care to the community.

The gear of mechanics represents the machinery, equipment and instrumentation, all balanced and coordinated to provide the hospital team with the tools and apparatus required throughout all areas, in all departments, and for the direct and indirect care of the patient.

The electric motor is representative of the electrical services that are necessary in providing the power for the many and intricate tasks of all. Some of the special activities, in a wide range of electrical engineering, include research on materials and electronic devices which are increasing in numbers in our hospitals; investigation into the laws of magnetic action electricity; design, control, application and maintenance; distribution and transportation; heating, lighting and power, including electronic devices; systems and equipment.

Symbolizing the mechanical (heating, ventilating, refrigeration, and air conditioning, and the plumbing systems of the hospital) is the hanger and pipe. The mechanical engineer makes use of the energies lying beyond the mere muscular control of man. By harnessing and distributing these energies, and even changing the shape and forces, he provides us with environmental surroundings that are most vital in our patient services of this modern and ever changing age of automation. In designing and specifying, the mechanical guidance provided gives us seven major products as a result of untiring research, development, and application. They are (1) tools; (2) apparatus and machinery; (3) handling equipment; (4) power generation equipment; (5) power transmission equipment (mechanical); (6) transportation equipment and (7) heat transfer equipment. Can you picture your hospital without any of these, singly or collectively? They perform the tasks that many of us take for granted.

Sanitation and prevention of the spread of disease are functions required in every instance and provided by adequate plumbing devices, systems and equipment. The

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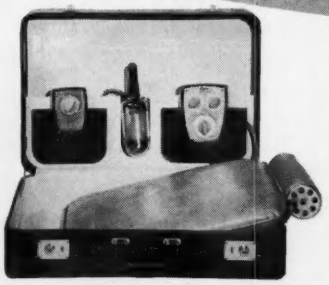

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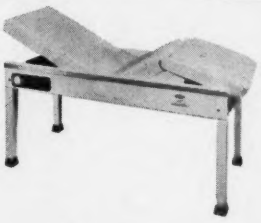

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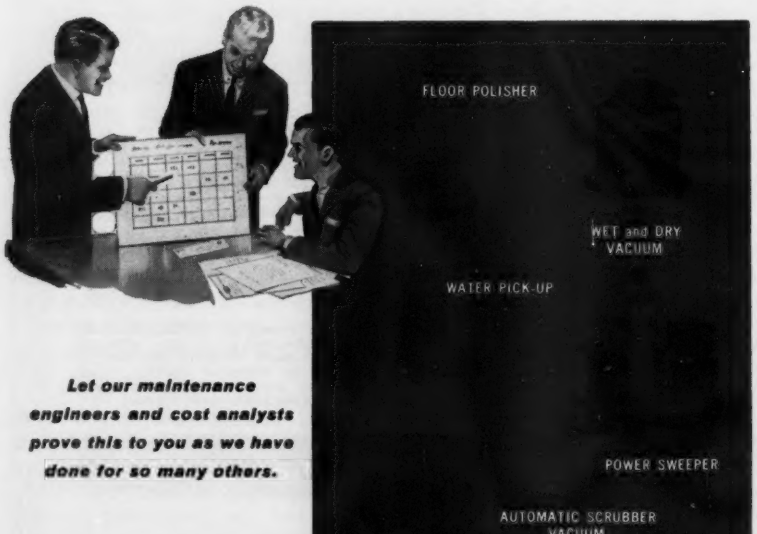

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civil engineer's contributions to the field of hydraulics (water supply, conservation, water works and drainage) and to the field of sanitation (public health, sanitary science, refuse disposal, sewage disposal) are far reaching accomplishments in providing comfort, health and conveniences for our hospitals.

All of the professions, skills and trades developed by the fields of design, mechanics, electronics and civil branches of our society surround, aid, and assist the profession for which our hospital facilities were originally conceived. The caduceus, or Hermes staff, represents the physician or medical corps of our institutions throughout the world. This is the profession upon which our functions as hospital lay personnel rotate: the focal point of our progress and purposeful existence in caring for the health needs of the community.

The emblem, viewed in its entirety, represents the profession of Hospital Engineering, and its collective forces at work, to heal the sick and comfort the afflicted.

The Committee of Professional Practice of the Engineers' Council for Professional Development has endorsed the following regarding the engineering profession:

"Engineering is the profession in which a knowledge of the mathematical and physical sciences gained by study, experience and practice is applied with judgment to develop ways to utilize, economically, the material and forces of Nature for the progressive well-being of mankind."

Through this symbol, and all that it signifies, let us all strive for a furtherance of these engineering principals and skills. ■

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for a copy of their 12-page booklet on "Centrifugal Pump Fundamentals."

Dan Roop, P.E., HOSPITAL MANAGEMENT engineering editor says—

This is a simplified, most practical approach to a problem which faces hospital engineers constantly. Through the study and use of the information in this booklet, economies can be realized in the purchase and operations of all types of centrifugal pumps. Every hospital engineer should have this booklet in his library for ready reference.

Tiemann and Lofren

Continued from page 86

The pharmacist advises the line executives on all matters pertaining to drugs, sick room and first-aid needs, both in the professional and business capacity.

There are six units comprising The Brown Schools, located in Austin and San Marcos, Texas. Each unit treats a certain type of emotional problem and age group.

Clinics are in operation in each of the units and registered nurses, on duty continuously, are responsible for administering all medication, which has been received from the pharmacy and kept in each clinic. Records are kept of all medication given, of new medication ordered by the doctors, and of any stop order on medication that the doctors wish discontinued.

The pharmacist, in the professional advisory capacity, maintains a constant check on the administering of all medication by the nurses and on records kept by them in every area where drugs are involved. He advises the coordinator of professional activities regarding the operation of each clinic and makes recommendations for improvement of medical service. The pharmacist also gives counsel to the doctors concerning any medication they may wish to use as to therapeutic effect, pharmacological action, dosage and administration. He also advises them of new products and of those being developed in this particular field of medicine.

In the business advisory capacity, the pharmacist advises the comptroller as to the expenditure necessary to maintain the clinics and the pharmacy and the equipment needed for their best and most economical operation. The accounting division is advised as to the cost of medication procured by the pharmacy and the proposed charge to the students.

Service

The pharmacist performs the service function for the line by stocking and dispensing all drugs to the students and supplying all sick room and first-aid needs to all units.

The pharmacy, located in the central office of The Brown Schools in Austin, maintains a formulary of drugs used by the doctors, and of the first-aid and sick room needs kept in the units.

All new and refill medications are ordered from the pharmacy by the registered nurse in each unit clinic on a student stock charge in duplicate. The original is sent to the pharmacy and a copy remains as the clinic record.

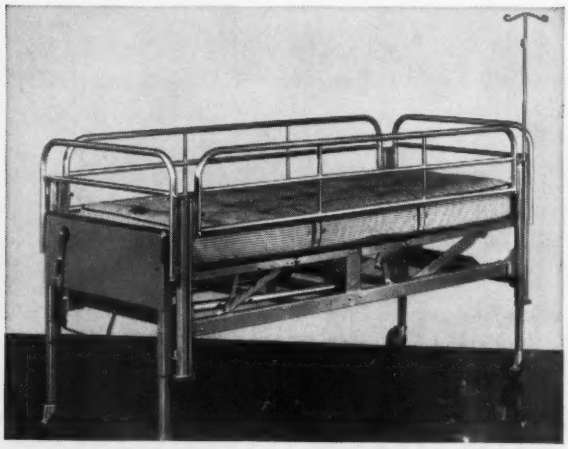
If the order is a new prescription left by the doctor with the nurse, a student stock charge is prepared and signed by the nurse, giving the date, the unit from which the order originates, the name of the prescribing doctor. Also, the new prescription written by the doctor is attached to the student stock charge and sent to the pharmacy for dispensing.

If the order is for a refill authorized by the unit doctor, the student stock charge is made stating the date, unit, name of the patient, the prescription number and the name of the medication. It also gives the name of the doctor authorizing the refill, and it is signed by the nurse.

For first-aid and sick room requirements in the unit clinics, a

Please turn to page 97

Sim-Matic Bed with new electronic switch—a major advance in bed positioning control. Gives patient complete control of bed height and spring positions, or control of spring positions only. Or nurse can flick cutoff switch to remove any or all movements from patient control. Clutch release permits automatic, separate operation for Fowler or Trendelenburg position. Nonshocking, nonsparking electronic conversion unit operates on 4-volt, milliamp current.



Vari-Hite Recovery Bed by Simmons—featuring unique versatility—to serve as recovery, eye or labor bed. The narrow width—36 in., including safety sides—permits easy access to patients, requires minimum space. As an eye bed, mattress raises to top of bed ends—patient can be reached from any desired angle. Bed quickly converts to an emergency delivery table by dropping the safety sides, raising spring to desired position and adding Bierhoff knee crutches.

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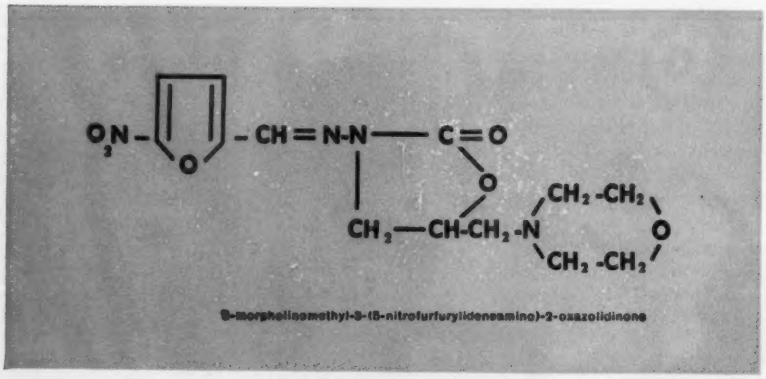

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Organism	*Sensitive*	*Resistant*	*% Sensitive*
Staphylococci*	181	1	99.4
Streptococci	65	1	98.5
D. pneumoniae	14	0	100.0
Coliforms	34	3	91.8
Proteus	5	5	50.0
A. aerogenes	8	0	100.0
Ps. aeruginosa	5	4	55.5

*Includes many strains resistant to antibiotics.

As with other nitrofuran compounds, development of bacterial resistance is negligible.

Clinically, ALTAFUR has proven most effective in the treatment of a variety of conditions including *pulmonary infections (pneumonia, empyema, bronchiolitis), upper respiratory tract infections, abscesses, cellulitis, pyodermas, septicemia/bacteremia and various wound infections.* ALTAFUR has produced cures in 75% of cases, and significant improvement in 10%.

To date, ALTAFUR has been used most extensively in staphylococcal infections with a cure rate of 66% and an improvement rate of 20%. Of particular importance, a number of these patients had not responded to previous therapy with antibiotics or other chemotherapeutic agents.

In common with the other available nitrofurans, ALTAFUR has a low order of side effects. Nausea and emesis occur occasionally but these can be minimized or eliminated through dosage adjustment and by giving the drug with meals and with food or milk on retiring. In the two instances in which a neutropenia developed, ALTAFUR was not clearly implicated. There has been no cross-sensitization of patients with other antibacterials.

The average adult dose is one 250 mg. tablet q.i.d. with meals and food or milk at bedtime. For severe staphylococcal infections, the dosage may be increased to approximately 30 mg./Kg. (13.5 mg./lb.) body weight per day, administered in four equally divided doses. The average length of therapy is five to seven days. Because this is a new drug, therapy probably should not be continued for more than 14 days except in severe or complicated cases, such as osteomyelitis, endocarditis, bacteremia (septicemia), etc.
Additional information may be obtained from the Medical Director, Eaton Laboratories.

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requisition form in duplicate is issued by the nurses for the items and amounts needed.

Since the units are in outlying areas and not in the same location as the pharmacy, the orders are transported by messenger each day to the pharmacy, and the medication is dispensed when the pharmacist comes on duty. The next day the messenger delivers the filled prescriptions and the requisition orders to the unit nurses.

Since the pharmacist is not on duty at all times, and in order to anticipate possible emergencies, an emergency kit is maintained in each unit clinic. For emergencies that cannot be handled by the contents of these emergency kits, arrangements have been made with a local retail pharmacy to supply such needs. These are delivered to the units at a cost to The Brown Schools of retail price less a previously determined percentage discount.

Control

The pharmacist also assists in control over operations. He performs this function by (1) establishment and maintenance of a formulary of drug stock; (2) the establishment and maintenance of emergency stock in all clinics; (3) purchasing; (4) record keeping; and (5) pricing.

The medical staff and the pharmacist have as one of their responsibilities the development of a basic drug list or formulary of accepted drugs for use in the hospital, which is added to and deleted from as the occasion demands.

Of the two general methods used in compiling formularies (grouping drugs according to pharmacologic and therapeutic classification and arranging all titles in alphabetical order) the first method was used because it enables the nurses and medical staff to correlate and remember the properties of similar substances and their therapeutic applications.[5]

Medication listed in this formulary is intended to cover the needs of one age group with similar physical and mental conditions, for it is with this group that The Brown Schools are concerned in offering its facilities of medical attention.

The table of contents of the formulary lists the following classifications:

1. Analgesics
2. Antibiotics
3. Anticonvulsants and Antispasmodics
4. Antihistamines
5. Biologicals — Serums, Toxoids and Vaccines
6. Diuretics
7. Laxatives
8. Sedatives
9. Stimulants
10. Sulfonamides
11. Thyroid and other Metabolic Stimulants
12. Tranquilizers
13. Vitamins

Under each classification the drugs are listed in alphabetical order according to generic name, the trade name or names, the use, the dose and the preparations stocked by the pharmacy. In the back of the formulary an extensive index and cross index of all drugs listed is maintained.

(Next month Part II will conclude this article).

[5]Martin, Eric W., and Cook, E. Fullerton: Remington's practice of pharmacy, Mack Publishing Company, 11th ed. 1956. p. 1525-1526.

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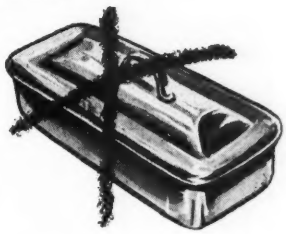

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Lattimer, John K., and Spirito, A. L.: Clorpactin for Tuberculosis cystitis: Instrument sterilization, *Journ. of Urology*, Vol. 73, No. 6, June, 1955. • Wolinsky, E., Smith, M. M. and Steenken, Wm. Jr., Tuberculocidal Activity of Clorpactin. A New Chlorine Compound, *Antibiotic Medicine*, 1:382-384, July, 1955. • Sanders, Murray and Soret, M. G.: Virucidal activity of WCS-90, *Antibiotics and Chemotherapy*, Vol. V, No. 11, Nov. 1955. • Gliedman, M. L., Lt. (MC) USNR, Grant, R. N. Capt. (MC) USN, Vestal, B.L., B.S., and Karlson, K. E., M.D.; Impromptu Bowel Cleansing and Sterilization, *Surgery*, 43:282-287. • From The Textbook, Extracorporeal Circulation, Edited by Dr. J. Garrott Allen, Page 87; Charles C. Thomas, Publisher.

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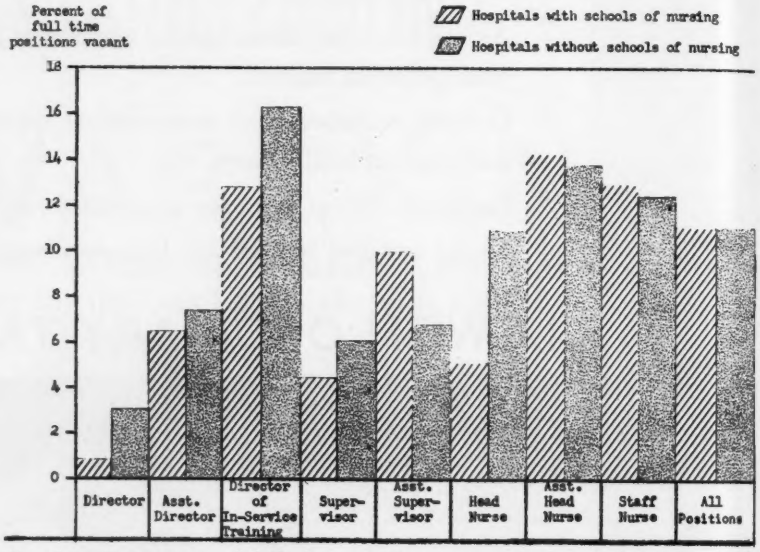
Vacancies for Professional Nurses in Non-Federal Hospitals, 1958

by Dorothy E. Reese
and Stanley E. Siegel

■ HOSPITAL AND NURSING administrators are concerned about vacancies which exist in nursing services. If a hospital has one or more vacancies for professional nursing personnel, this may mean the curtailment of certain essential nursing activities. It may mean that assistance was not available to help a patient, or that a nursing aide was not getting the supervision she needed to function adequately as a member of the nursing team. Since hospitals utilize the services of 60 percent of all professional nursing personnel, the importance of these vacancies cannot be overemphasized.

More than ten percent of all full-time nursing service positions were vacant in non-Federal hospitals in 1958. Moreover, as many as 34 percent of these hospitals had one or more vacancies.

In March 1958, the Division of Nursing Resources, Public Health Service, U.S. Department of Health, Education, and Welfare sent a questionnaire to a random sample of non-Federal hospitals to obtain information about current vacancies.[1] Eight levels of professional nursing service positions ranging from director of nursing service to staff (general duty) nurse were included on the questionnaire sent to



Graph 1. Percentage of full-time positions vacant in hospitals with schools and without schools of nursing

TABLE 1. — Number of Full-Time Authorized Budgeted Vacancies in Nursing Service in Non-Federal Hospitals as of January 31, 1958

Hospitals	Authorized budgeted vacancies (No.)	Employed full-time (No.)	Total positions	Full-time positions vacant (%)
With schools	8,946	70,886	79,832	11.2
Without schools	13,431	106,654	120,085	11.2
Total	22,377	177,540	199,917	11.2

TABLE 2. — Number of Hospitals Having One or More Full-Time Positions Vacant in Nursing Service, by Size of Hospital

No. of beds (size group)	Hospitals with schools of nursing: No. in each size group	Hospitals with schools of nursing: Hospitals with one or more positions vacant (No.)	Hospitals with schools of nursing: Hospitals with one or more positions vacant (%)	Hospitals without schools of nursing: No. in each size group	Hospitals without schools of nursing: Hospitals with one or more positions vacant (No.)	Hospitals without schools of nursing: Hospitals with one or more positions vacant (%)
Under 50	.....	.....	.....	2,763	430	15.6
50-149	181	91	50.3	1,666	570	34.2
150-299	371	208	56.1	462	269	58.2
300-499	208	163	78.4	118	86	72.9
500 & over	91	68	74.7	301	215	71.4
Total	851	530	62.3	5,310	1,570	29.6

Dorothy Reese is Nurse Consultant Division of Nursing Resources, Public Health Service, Department of Health, Education and Welfare.

Stanley Siegel is Assistant Chief, Statistical Analysis, Division of Nursing Resources, Public Health Service, Department of Health, Education, and Welfare.

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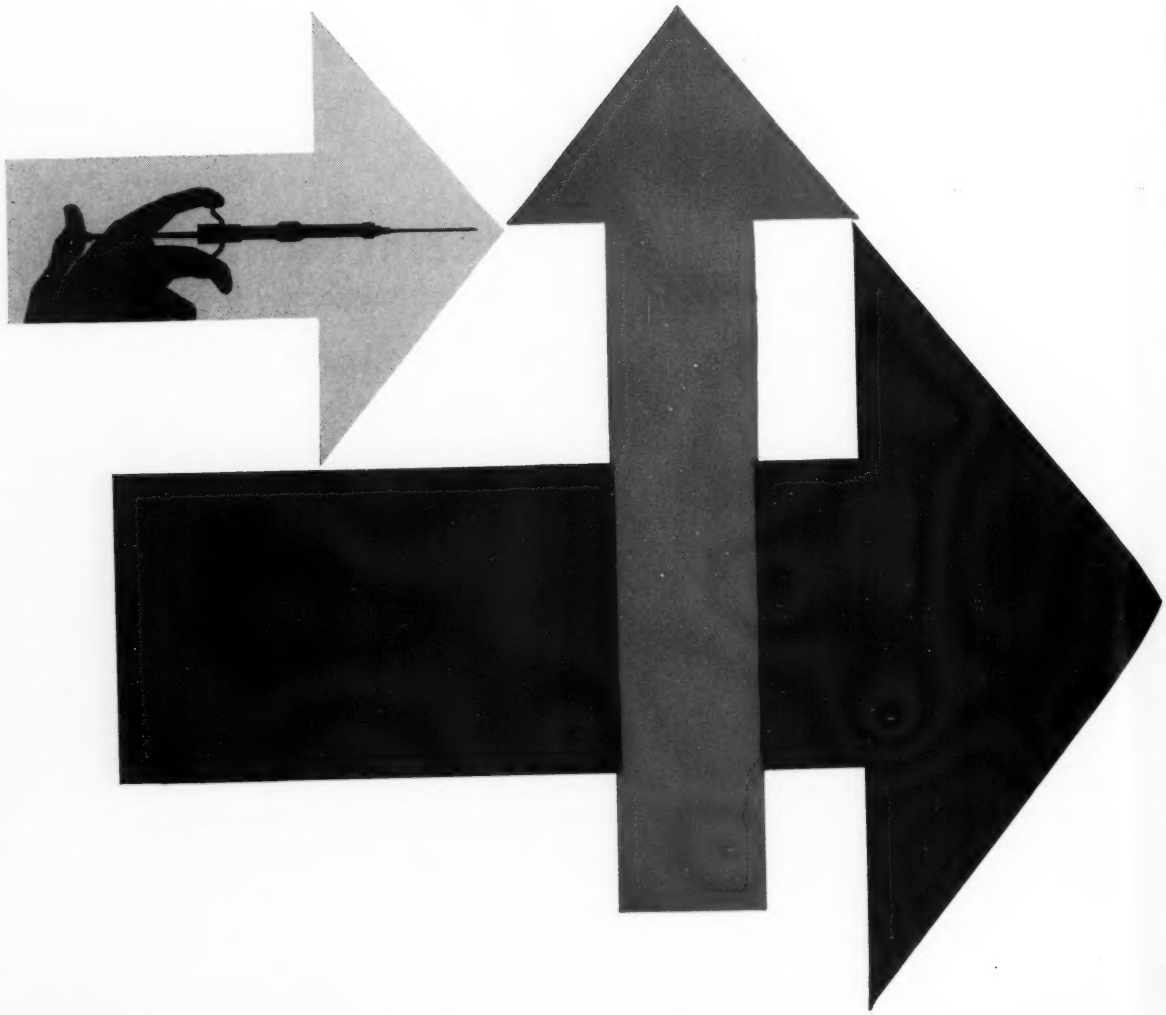

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205 (188-91.7 percent responded) hospitals with schools of professional nursing[2] and to 737 (494-67 percent responded) hospitals without schools of professional nursing.[3] The data *(graph 1)* show a projection of these responses to the nation as a whole—851 hospitals with schools, and 5310 hospitals without schools of nursing.[4]

TABLE 3. Number of Vacancies in Hospital with Schools of Nursing and Percentage of Positions Vacant According to Nursing Service Position and Bed Size of Hospital

Nursing service positions and Bed size of hospitals	Authorized budgeted vacancies (No.)	Employed full-time (No.)	Total positions	Full-time positions vacant (%)
A. Director of Nursing Service				
Under 50	.....	.....	.....	.....
50-149	5	109	114	4.4
150-299	0	227	227	0.0
300-499	0	176	176	0.0
500 & over	0	72	72	0.0
Total	5	584	589	0.8
B. Assistant Director of Nursing Service				
Under 50	.....	.....	.....	.....
50-149	27	195	222	12.2
150-299	41	612	653	6.3
300-499	36	485	521	6.9
500 & over	0	262	262	0.0
Total	104	1,554	1,658	6.3
C. Director or Instructor of In-Service Training				
Under 50	.....	.....	.....	.....
50-149	18	73	91	19.8
150-299	45	223	268	16.8
300-499	14	140	154	9.1
500 & over	0	99	99	0.0
Total	77	535	612	12.6
D. Supervisor				
Under 50	.....	.....	.....	.....
50-149	50	715	765	6.5
150-299	68	2,000	2,068	3.3
300-499	91	1,633	1,724	5.3
500 & over	63	1,595	1,658	3.8
Total	272	5,943	6,215	4.4
E. Assistant Supervisor				
Under 50	.....	.....	.....	.....
50-149	14	127	141	9.9
150-299	27	376	403	6.7
300-499	18	327	345	5.2
500 & over	63	280	343	18.4
Total	122	1,110	1,232	9.9
F. Head Nurse				
Under 50	.....	.....	.....	.....
50-149	27	1,020	1,047	2.6
150-299	82	3,887	3,969	2.1
300-499	154	3,129	3,283	4.7
500 & over	380	4,050	4,430	8.6
Total	643	12,086	12,729	5.0
G. Assistant Head Nurse				
Under 50	.....	.....	.....	.....
50-149	91	270	361	25.2
150-299	217	1,610	1,827	11.9
300-499	145	1,202	1,347	10.8
500 & over	231	932	1,163	19.9
Total	684	4,014	4,698	14.6
H. Staff Nurse				
Under 50	.....	.....	.....	.....
50-149	204	3,799	4,003	5.1
150-299	1,599	16,432	18,031	8.9
300-499	2,921	14,521	17,442	16.7
500 & over	2,315	10,308	12,623	18.3
Total	7,039	45,060	52,099	13.5

Definitions

Director of Nursing Service: professional nurse responsible for the organization and administration of the nursing services of a hospital.

Assistant Director of Nursing Service: professional nurse who assists with the administration of the nursing services during the day, evening, or night.

Director or Instructor of In-Service Training: professional nurse responsible for the in-service educational program, the organized educational programs for all levels of nursing staff.

Supervisor: professional nurse responsible for supervising nursing service of two or more units (or wards) of the hospital during the day, evening, or night. These units may include operating room suite, central supply, outpatient or other departments for which nursing personnel carry responsibility.

Assistant Supervisor: professional nurse who assists in the supervision of the nursing service of two or more units during the day, evening, or night.

Head Nurse: professional nurse who is responsible for the administration of the nursing service of a single nursing unit during the day, evening, or night.

Assistant Head Nurse: professional nurse who assists the head nurse during the day, evening, or night.

Staff (General Duty) Nurse: professional nurse who is directly responsible for patient care under the supervision of a head nurse or her assistant.

Estimated full-time vacancies

It is estimated that 22,377 nursing service positions were vacant in non-Federal hospitals for the nation as a whole *(table 1)*. This is in substantial agreement with the full-time vacancy rate in non-Federal general hospitals as deter-

[1]Data collected for use by the Evaluation Conference, Professional Nurse Traineeship Program, August 1958.

[2]Selected from "Schools of Professional Nursing 1957," Committee on Careers, National League for Nursing.

[3]Selected from a list supplied by the American Hospital Association.

[4]The method by which the sample was projected to the national totals is available from the Division of Nursing Resources, Public Health Service, Washington 25, D.C.

[5]American Nurses' Association: Facts about nursing. 1958, page 15.

mined by the American Nurses' Association surveys in 1954 and 1956.[6]

This estimate of vacancies is probably conservative as only authorized budgeted vacancies were reported. A Maryland hospital administrator gave another reason supporting the probability that the figures given are low:

"Simply not enough nurses to go around. We no longer designate the number needed as it is so far above what we can expect to get. We have 26 L.P.N.'s (Licensed Practical Nurses) filling R.N. positions at present and are still extremely short of nursing help."

Also, authorized budgeted vacancies could not reflect the number of professional nurses needed to staff hospital facilities now undergoing expansion.

Full-Time Vacancies

Vacancy data *(table 2)* were analyzed according to hospital size groups and by type of nursing service position. The largest percentage of vacancies in hospitals with schools of nursing occurred in the 50 to 149 bed size group for the positions of director of nursing service, assistant director of nursing service, director or instructor of in-service training, supervisor, and assistant head nurse. The greatest percentage of vacancies for the positions of head nurse and general staff nurse were found in hospitals of 500 beds and over *(table 3)*.

Unlike hospitals with schools, the highest percentages of positions vacant were not concentrated in the size group 50-149, but occurred in all size groups *(table 4)*.

Vacancies for Part-Time Personnel

Table 5 indicates that 52,423 nurses worked part-time in nursing service. This sizeable number may be due in part to the definition of part-time used in this study which was as follows. Professional nurses who were either employed full-time but spend only part-time on nursing service activities (For example: a supervisor in a hospital with a school of nursing having some responsibilities for nursing education would be considered as part-time for the purposes of this study) or employed part-time for nursing service activties.

About half of these vacancies (577) were for staff nurse positions, and the remainder were scattered among other positions *(table 6)*.

While part-time personnel are helping to meet a critical need in nursing services in hospitals today, some comments were made by administrators expressing a preference for full-time staff members. For example:

"A continual attempt is being made to replace part-time with

TABLE 4. Number of Vacancies in Hospitals Without Schools of Nursing and Percentage of Positions Vacant According to Nursing Service Position and Bed Size of Hospital

Nursing service and Bed size of hospitals	Authorized budgeted vacancies (No.)	Employed full-time (No.)	Total positions	Full-time positions vacant (%)
A. Director of Nursing Service				
Under 50	51	2,074	2,125	2.4
50-149	63	1,692	1,755	3.6
150-299	25	467	492	5.1
300-499	0	152	152	0.0
500 & over	25	289	314	8.0
Total	164	4,674	4,838	3.4
B. Assistant Director of Nursing Service				
Under 50	63	532	595	10.6
50-149	75	1,148	1,223	6.1
150-299	51	606	657	7.8
300-499	25	277	302	8.3
500 & over	51	696	747	6.8
Total	265	3,259	3,524	7.5
C. Director or Instructor of In-Service Training				
Under 50	0	87	87	0.0
50-149	63	329	392	16.1
150-299	101	315	416	24.3
300-499	38	101	139	27.3
500 & over	51	468	519	9.8
Total	253	1,300	1,553	16.3
D. Supervisor				
Under 50	168	1,978	2,146	7.8
50-149	215	4,420	4,635	4.6
150-299	140	1,686	1,826	7.7
300-499	9	605	614	1.5
500 & over	187	2,809	2,996	6.2
Total	719	11,498	12,217	5.9
E. Assistant Supervisor				
Under 50	19	280	299	6.4
50-149	19	1,256	1,275	1.5
150-299	47	281	328	14.3
300-499	55	201	256	21.5
500 & over	37	532	569	6.5
Total	177	2,550	2,727	6.5
F. Head Nurse				
Under 50	235	2,820	3,055	7.7
50-149	687	5,851	6,538	10.5
150-299	318	2,751	3,069	10.4
300-499	84	1,323	1,407	6.0
500 & over	830	4,417	5,247	15.8
Total	2,154	17,162	19,316	11.2
G. Assistant Head Nurse				
Under 50	42	325	367	11.4
50-149	92	1,579	1,671	5.5
150-299	142	882	1,024	13.9
300-499	134	495	629	21.3
500 & over	311	1,182	1,493	20.8
Total	721	4,463	5,184	13.9
H. Staff Nurse				
Under 50	863	10,791	11,654	7.4
50-149	1,646	26,099	27,745	5.9
150-299	1,796	1,996	3,792	47.4
300-499	1,128	5,139	6,267	18.0
500 & over	3,545	17,723	21,268	16.7
Total	8,978	61,748	70,726	12.7

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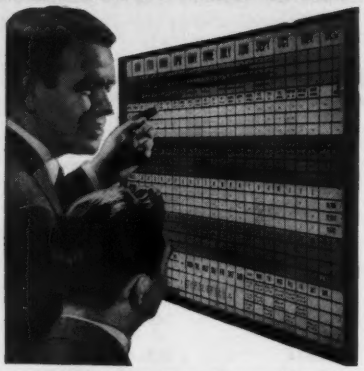

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TABLE 5. Number of Part-Time Authorized Budgeted Vacancies in Nursing Service in Hospitals as of January 31, 1958

Hospitals	Part-time authorized budgeted vacancies (No.)	Employed part-time (No.)	Total positions	Part-time positions vacant (%)
With schools	219	25,160	25,379	0.9
Without schools	915	27,263	28,178	3.2
Total	1,134	52,423	53,557	2.1

full-time; however, in total nursing hours we are up to budget." (New York)

"We would very much like to replace part-time nurses with full-time nurses if they were available." (New Jersey)

"Nursing service could be carried out with greater efficiency if the hospital were not as dependent upon part-time personnel." (Virginia)

Reasons for Vacancies

Hospitals which reported authorized budgeted vacancies were asked to indicate the most important reasons, in their opinion, for these vacancies. The reason cited most often was that *qualified nurses were not obtainable.* This represented 41 percent of responses of hospitals with schools and 50 percent of responses of hospitals without schools. It was given by all hospitals reporting, regardless of their size.

Two hundred and forty hospitals reported vacancies in clinical fields for reasons such as:

"Difficulty in finding nurses who are interested in surgery." (California)

"Personnel not available in such specialties as delivery room, psychiatry, rehabilitation." (Missouri)

"Unable to find a qualified nurse to take Head Nurse's position in pediatrics." (New Jersey)

Other reasons expressed included unpopularity of certain tours of duty such as evening and night, isolated and rural locations. Personal reasons such as marriage and pregnancy were also given.

Projected estimates indicate that 2100 or 34 percent of all hospitals had one or more positions vacant in 1958. Approximately 11 percent of all full-time professional nursing service positions were vacant in hospitals with and without schools of nursing. The variation in percentage of positions vacant by size of hospital and type of position *(tables 3 and 4)* should give a more adequate picture of vacancies today. ■

TABLE 6. Number of Part-Time Authorized Budgeted Vacancies and Percentage of Positions Vacant, by Category of Nursing Service Positions

Category of nursing service positions	Part-time authorized budgeted vacancies (No.)	Employed Part-time as of 1/31/58 (No.)	Total	Part-time positions vacant (%)
Hospitals with schools of Nursing				
Director of Nursing Service	0	304	304	0.0
Asst. Director of Nursing Service	5	376	381	1.3
Director or Instructor of In-Service Training	23	217	240	9.6
Supervisor	23	870	893	2.6
Asst. Supervisor	0	177	177	0.0
Head Nurse	32	471	503	6.4
Asst. Head Nurse	0	1,590	1,590	0.0
Staff Nurse	136	21,155	21,291	0.6
All categories of nursing service positions	219	25,160	25,379	0.9
Hospitals without schools of Nursing				
Director of Nursing Service	355	505	860	41.3
Asst. Director of Nursing Service	11	355	366	3.0
Director or Instructor of In-Service Training	11	409	420	2.6
Supervisor	75	2,215	2,290	3.3
Asst. Supervisor	0	333	333	0.0
Head Nurse	11	1,688	1,699	0.6
Asst. Head Nurse	11	290	301	3.7
Staff Nurse	441	21,468	21,909	2.0
All categories of nursing service positions	915	27,263	28,178	3.2

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Continued from page 51

struction of the mineral compounds with which we will be dealing. They are comprised of two parts, the front part of the compound is called a cat-ion and the latter part of the compound is called an-ion. The cat-ion is the positively charged portion, and the an-ion is the negatively charged portion. Referring to the basic principles of electricity you will recall that like charges, that is positive and positive and negative and negative repel each other. On the other hand, positive and negative charges are attracted to each other. The positively charged particles, or ions, with which we are concerned are calcium, magnesium, sodium and, to a lesser extent, iron and possibly potassium. These elements are all positively charged in the compounds with which we deal and they are usually tied up with anions, or negatively charged particles, which are called carbonates, bicarbonates, sulfates, chlorides and, to a lesser extent, nitrates. Thus, we have a positively charged calcium and negatively charged sulfate, and these two are attracted to each other in the chemical world of solution to form calcium-sulfate, or $CaSO_4$. Now, these salts of calcium and magnesium are the ones that are primarily responsible for the hardness content of water and produce scale in boilers.

Water Softening

In the process of ion exchange (water softening) the name describes quite well the principle of the process. We have a material in a vessel or tank through which our water supply will flow. This ion exchange material is comprised of a complex organic material to which is attached a positively charged sodium ion. As the water solution containing calcium and magnesium trickles through this bed of exchange resin, the calcium and/or magnesium attaches itself to the resin bed and the sodium and then by natural reaction removes itself from the bed and attaches itself to the negatively charged ions, which were previously captured by the calcium and magnesium. Thus, when the water comes through the bottom of the softener tank, it does not contain calcium and magnesium salts, but rather it contains sodium salts, such as sodium sulfate, sodium bicarbonate, sodium carbonate. Now we might say, what have we gained? The only thing that we have gained, and it is an important gain, is that we now have a salt solution that is much more soluble under boiler conditions than we would have had if we had not used the exchange system. The sodium salts will stay in solution and produce steam from the water without depositing a scale on the waterside surfaces of steam generating units. This is true as long as the solubility of the sodium salts is observed. But, indeed, if this is exceeded, one can develop water soluble scales and deposits. This rarely occurs because the normal blowdown schedule of most boiler units does not allow this excess to develop. It is important to recognize that we have done absolutely nothing to reduce the total dissolved solids of the water, and to a measure we have restricted our ability to concentrate the water in the boiler unit. This is one of the detriments of straight sodium zeolite softening, which must counter-balance its attractions. These are ease of operation with the use of nontechnical personnel and the cheapness of the regeneration medium used to replace the sodium once the bed has been depleted. This replacement medium is inexpensive sodium chloride.

The second type of pretreatment is by means of precipitating the calcium and magnesium salts. This is accomplished in a vessel by adding lime and soda ash to the water which effects a precipitation of these salts. A coagulant is sometimes used and the precipitate is removed from the bottom of the vessel as sludge. The effluent from these systems usually passes through a filter to assure the removal of tardy precipitates and that portion of the sludge that is entrained with the water. This type of pretreatment applies particularly to waters of high hardness and, where it is carried out at elevated temperatures, can produce a water of very high quality with a substantial reduction of the total dissolved solids.

Boiler Water Treatment

It is now time to discuss the common practice of adding chemicals to the boiler itself. These applications fall into two categories. The first is known as after-treatment and it supplements some form of pretreatment. The degree and quality of pretreatment determines the type and the amount of chemicals supplied to the boilers. In most cases these chemicals are supplied to overcome the corrosive tendencies of softened or demineralized water, and to precipitate traces to small amounts of hardness escaping the pretreatment. The basic principle of internal boiler water treatment, when used alone, as far as scale formation is concerned, is not greatly different than the precipitation method of pretreatment. To offset the scale forming tenden-

Please turn to page 124

Let's Play It Safe

WRONG: This picture demonstrates poor posture for lifting and carelessness in leaving a cabinet door open.

RIGHT: Keep upper shelf doors closed when not in use. When bending do it from the waist, keeping the back as straight as possible.

NATIONAL ASSOCIATION OF HOSPITAL PURCHASING AGENTS

Mrs. Orpha Daly Mohr
Secretary-treasurer
National Association of Hospital Purchasing Agents
Chicago Wesley Memorial Hospital
250 East Superior Street
Chicago 11, Illinois

Purchasing and Rising Cost

by William J. Viers
Purchasing Agent
Caldwell Memorial Hospital
Caldwell, Idaho

Purchasing is entering into a new era, with a much broader expanse of responsibility. Purchasing is becoming a part of management, inheriting many of the problems of the management field.

With long strides into a realm of research and study, the purchasing role in the hospital field, is stepping out far beyond the clerical domain of the past.

The rising incline of hospital rates, has made management more and more conscious of the importance of the specialized purchasing field. The purchasing department is being consulted to a greater extent as to the problems of increasing costs in the hospitals.

The economics picture is constantly changing in the world of today. There is no relief in the foreseeable future from increasing prices and the higher cost of operation. Management has to look somewhere to find help in cutting some of these costs. That place can be in the purchasing department.

With a bit of planning and common sense, the purchasing department can develop a science sense, so to speak. Inquiry, research and study is going to be the thing that purchasing must develop far beyond its present realm.

A look into the present and the future can help a great deal in control of prices and cost. Let's look at the present, to begin with. A purchasing agent should and must be in contact with every department in the hospital. With this contact, he can rapidly develop a sense which will tell him where items are being used in excess or being literally wasted.

Once an area of waste has been found, the purchasing department should then begin an educational program. Make each department involved conscious as to the cost of the item and how it should be used. Then point out how the department can make a saving to the hospital by correct usage.

An educational program, such as this, can be carried on throughout the hospital in a pleasant manner, and still achieve results. The main thing is to impress cost consciousness on each department in the hospital. Of course, this must be done in a sensible manner, or the desired co-operation can not be achieved.

Once a program has been introduced to cut waste, the purchasing department must then turn part of its attention to the problem of ascending prices of supplies.

Actually, if a little research and study is put into this problem, many substitutes or other brands can be found that are as high in quality, as the brand item that is now in use. Many companies are remaining stable in their prices, while the more advertised competitor is having to raise prices due to rising advertising costs and a variety of other reasons that do not directly involve the quality or improvement of the product. In many cases, brand names mean neither quality or reasonable prices.

The purchasing department can take one item at a time, study the price list of each manufacturer who produces this one product, there are usually quite a few, then check for quality. The purchasing department will soon find that there are many items that are equal in quality to the product presently being used and lower in cost. In this search, the department may find a good substitute that will do the same job for a fraction of the cost.

The future outlook remains to be seen. A purchasing department can pay close attention to market trends. Achieving a more co-operative attitude from the jobbers can be helpful. Also, a purchasing department can make every item purchased competitive and have an effect on future prices.

With expanding responsibilities as purchasing agents, we must think of the hospital and, most important, we must dedicate ourselves to the public and the patients whom we serve. Keep in mind that waste and unorganized buying effects the patient's pocketbook and lessens the good service the patient deserves.

Now that this field is developing into a position of responsibility, a purchasing department can prove that it is a self-sustaining department. ■

A Purchasing Agent's Viewpoint

IS GROUP PURCHASING PRACTICAL?

by S. E. Holland
Purchasing Agent
Akron General Hospital
Akron, Ohio

The question of group purchasing in hospitals has always been a controversial subject. Even hospitals in the same city within walking distance of each other have taken opposing views on the subject.

Until recently the question of group buying has been left entirely to the hospital administrator; but now, with the purchasing agent assuming the role of leadership in his institution, the administrator is looking to the buyer to advise and guide him to the correct answer to the question, "Is group purchasing practical in hospitals?"

If we as purchasing agents are to advise and guide our individual hospitals on this important question, we must be prepared with as much knowledge on the subject as we are able to obtain.

Let's look at group purchasing from the positive viewpoint. Today in this country there are over 12,000 trade associations. These associations are to be found in all types of businesses, large and small. They provide for their industries in addition to purchasing information such important detail as sales trends, shipping information, wage rates, and research reports. It is this exchange of information that has helped to make America.

Group purchasing started in industry and hospitals at approximately the same time, around the year 1910. Hospitals, however, were not ready to accept this new method of purchasing and information. This is proven by the fact that today we have only a handful of hospital purchasing groups while industry has thousands of such organizations.

The largest hospital trade association is the Hospital Bureau of New York, composed of about 200 hospitals and three hospital councils; the Cleveland Hospital Council is included in this group.

Hospitals in our country spend three billion dollars annually. This puts our hospitals in the upper ten of "big businesses."

We have not kept pace with our friends in industry. We were not ready and perhaps not able in 1910; but today in our hospitals of big business we *must* accept "group purchasing" as a means of economy, standardization and research information.

As hospital purchasing agents we are expected to provide the supplies and equipment needed, at the right time, in the right quantity and at the right price.

Since most individual hospitals have reached the present point of efficiency in these requirements on their own, there is no place left to turn but to group purchasing to further improve our purchasing. Even in our own homes we seldom buy at the corner grocery store. We deal rather with the large super market which is able to offer us greater values.

Group purchasing offers our institutions the tools to do a better and more efficient job.

1. An exchange of information and experience and trends with others in our field.

Through various meetings and published reports, information comes from others in similar positions as a helpful guide to our own thinking.

2. Research Information

Few of us are able to do a good job of research on our own, due to lack of time and equipment; but with an organized group such as the Hospital Bureau or Cleveland Council, research information is available.

3. Standardization

Standardization of such items as dressings can more readily be handled by an organization with knowledge of the needs of a number of hospitals.

Do we need many different gauzes with varying thread counts, is it practical to use many sizes and styles of sponges?

This type of question would be difficult for us as individuals to answer; but a trade organization such as the Hospital Bureau with its combined knowledge of a number of institutional requirements and needs is in a position to guide us. And since we as individuals supply them with the necessary detail we do not give up any of the desired features of a product when it is standardized. As purchasing agents we have definitely been lacking in the area of standardization. Many purchasing agents buy as many as three or more similar items when one or two at the most would suffice. This is not a good business practice.

4. *Price advantages without loss of quality.*

It has been known from ancient times that there is strength in numbers. That is why the kings of old combined their military might. We did the same thing in the last World War.

There is definitely more purchasing power in a group than if we each purchased our own supplies on an individual basis.

The individual hospital that purchases five cases of gauze sponges certainly cannot make the purchase as economically as a group purchasing 200 or more cases of the same item.

Group purchasing is a means of savings for our hospitals and for our patient.

While group purchasing may be of greater importance to the smaller hospital, let us not overlook the fact that even the large institution will receive certain benefits

This paper was presented at the June sectional meeting of the Northeastern District Purchasing Section of the Ohio Hospital Association, June 19, 1959.

not available without the group as a whole. Perhaps the price advantage is not so great to the larger hospital but certainly the research information, standardization effort, and general trends of the time are important. And after all, if we aid the smaller hospital we, in turn, help our community and our own hospital. There is strength in numbers and the larger community hospital certainly should join to aid the smaller institution.

Group hospital purchasing definitely has a depressing effect on prices. For example:

In the 1930's there were three sources of dressing supplies and the Hospital Bureau had an agreement with one of them.

The Bureau's agreement was cancelled when its source of supply was purchased by one of the other two major suppliers. Within six months the cost of bolt gauze had jumped 25 cents per bolt.

When the Bureau again was able to write an agreement with another reputable supplier the price of bolt gauze again dropped from $2.00 to $1.40 per bolt. This price was immediately met by the two major suppliers which had just recently increased their price when the Bureau dropped from the picture.

X-ray film would be another good example of the effect of group purchasing as opposed to individual action.

Few if any discounts were available on X-ray film prior to 1949 when the Hospital Bureau came into the picture. While this contract was in force between 1949 and 1954 many suppliers offered discounts of from five to 10 percent. When the contract was cancelled in 1954 discounts in the field were generally dropped or reduced.

In 1955 when a new film agreement was written by the Bureau for its members, discounts were again offered. In fact, in my own hospital within the last few months two companies have offered additional discounts to encourage me to purchase film from them. There was no change in quality or type. The film brand name remained the same. Group purchasing definitely has a depressing effect on prices!

Group buying saves you time. Since your group (and you are part of that group) has already studied and evaluated and even contracted for various items, your time is saved. You merely check the purchase agreements available to you and place your order accordingly.

Now since we have decided that group purchasing is practical, where do we begin to set up and accept the advantages available to us?

There is the Hospital Bureau in New York City which offers membership to interested hospitals.

For hospitals in surrounding communities you might try what we did in Akron. First, we obtained administrative approval to evaluate local group purchasing; and then last November we combined for quotations all the dressing requirements of the four hospitals for a period of one year.

The prices received were for quality dressings and in each case meant a financial savings to our hospitals. The greater saving was, of course, to the smaller hospitals; however, there was a cash saving to all hospitals.

In order that you do not get the opinion that there were no problems involved let me tell you of two difficulties which arose.

Two of our hospitals had a change of buyers during the period of price negotiations.

One of the larger hospitals requested prices on its own. The prices given to this hospital were for all practical purposes the same as those given to the group. But, bear in mind one fact; these prices were not given to this particular hospital until after our group prices had been received. This hospital is still supporting our small group in such areas as dressing standardization. They will, we hope, join with us in future attempts at group purchasing.

The second step, taken as a group, was an attempt at dressing standardization. After a decision to maintain the quality of the various dressing items currently used; the group with the aid of the O.R. and Central Service supervisors made certain recommendations to the various hospitals which resulted in the use of fewer dressing items of a similar nature. All of these hospitals are now using the same general items so that the various physicians are using the same item regardless of which hospital he is in.

Our next step this fall is to attempt to place paper items and textiles under contract through the group.

In years to come we hope to broaden our scope and include testing and research. We also hope to combine training and education as time permits.

Three additional hospitals in the area have requested to join with us in future projects.

Up to now, all of the information presented has been on the positive side. Let's look at some of the claimed disadvantages as offered by the opponents of group purchasing.

1. We lose the advantages of visits from salesmen who may be able to give us new and current information.

My hospital has always been a member of a purchasing group. I see as many salesmen as any buyer in my area who is not currently in a group. These salesmen still call on me to give me help in the many items not covered by my group contracts.

As to general product information the representatives of the group contract holders still make periodic calls and my group will provide bulletins giving information.

2. Some claim that we cannot expect the service as a group that is available singly.

Which buyer may expect better service, the small one or the large one? The large one, of course, since there is more at stake for the supplier. And each member regardless of size is a portion of that large group.

3. Some say we owe it to our community to purchase locally.

There are very few hospitals which purchase all of its supplies locally whether a member of a group or not. I have never known of a supplier having to go out of business because of group purchasing; and, if better prices are available, we owe it to the members of our community to take advantage of the situation. This is, of course, a service to the patient as well as to the citizens of our area.

4. Some claim that groups tend to cut quality and deal with disreputable suppliers.

If you will check with the Cleveland Council, you will find that they have many contracts with nationally known, well-recognized suppliers. This is true of the Hospital Bureau also. Quality is not sacrificed.

5. Some purchasing agents claim that by joining a purchasing group their jobs may be at stake.

This cannot be farther from the truth since more time will be available for improvement in other areas of the operation. No hospital will ever make all of its purchases through a group source; but more time will be available to spend on routine purchases, thus allowing for a better job on these items.

6. Some claim that suppliers are opposed to group purchasing.

This is true, I am sure, for certain suppliers; however, those companies on their toes are always willing to ac-

cept volume business which is assured when a group participates in an agreement. Those suppliers which refuse to make any price concessions will complain, but haven't they been complaining for years?

In certain ways a group acts as a sales representative for the various suppliers since the members are interested in advancing their own organization.

I feel it definitely is an advantage to any hospital to belong to a purchasing group.

Do not expect overnight advantages from any group which you may join. It takes time, perhaps as much as several years. Also, remember that any organization is no better than its members.

You must share your special abilities and knowledge and experience with other hospitals. The greater the number of members in your group the better results you may expect.

Relations among the member hospitals will, in turn, be improved when all cooperate in a group endeavor since to function properly the membership must be on a contributory basis.

Sooner or later your hospital will be doing group purchasing. Why not consider it now? ■

Next month we will have an administrator's point of view on "Group Purchasing."

The "Sixty-Four Dollar Question" Column

Permission to reprint this Column each month for the National Association of Hospital Purchasing Agents was granted by Mr. Frank M. Rhatigan, secretary of the American Surgical Trade Association.

QUESTION: By whom is the Sass-Wolff stoma biliary endoscope made?
ANSWER: Available from Medisco, Inc., 155 W. 72nd St., New York 23, N. Y.

QUESTION: Have you any information on a stereophonic stethoscope with double chest pieces, which is thought to be called a Gonoscope or Ergoscope?
ANSWER: The Symballophone (or Symbela Phone) has two chest pieces arranged so they provide directional capacity. Can be ordered through the Department of Medicine, University of California, Attention: Mrs. M. Kluge, Secretary, with checks payable to Dr. Wm. J. Kerr.

QUESTION: What is the name and address of the distributor of Betafil, a surgical silk sold in a container holding an antiseptic solution?
ANSWER: Correct name is Vetafil Bengen. It is a smooth plastic, protein suture solely imported to our country from Germany by Dr. S. Jackson, 4713 Colorado Ave., N.W., Washington, D.C. It is used widely by veterinarians.

QUESTION: Who makes the Stabler needle sharpener?
ANSWER: Several years ago Mr. Robinson R. Stabler, 428 Southeastern Building, Greensboro, N. C. designed a needle sharpener and also a smaller instrument for removing the burrs from needles. However, they were never marketed. Anyone interested in these items should contact Mr. Stabler.

The "brain" says we don't need any!

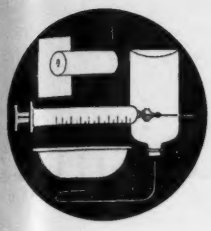
QUESTION: From whom is the Wood-Doig gastric biopsy tube available?
ANSWER: It was developed by H. A. Taylor, Melbourne, Australia, along with the Woods intestinal biopsy forceps. Available from the Surgical Mfg. Co. Pty. Ltd., 378 Lonsdale St., Melbourne, C.1, Australia.

QUESTION: Advise source of supply, or someone who stocks, two Thudicum nasal douches, pint size. No longer made by Glasco or Armstrong.
ANSWER: Bischoff's Surgical House, 166 S. 2nd St., San Jose 18, Calif. has four which they will sell. Anderson Surgical Supply Company, St. Petersburg, Fla. has two which they will sell.

QUESTION: *Can you advise source of supply of a plastic bag used for autoclaving instruments?*
ANSWER: Fannin & Co., Ltd., 41 Grafton St., Dublin, Ireland, makes such a bag of nylon, which permits steam penetration but not bacteria penetration.

QUESTION: *Who distributes English-made bone cement in this country?*
ANSWER: This may refer to Luckens Bonewax commonly used as a bone cement for hemostasis. It is manufactured after the formula of Sir Victor Horsely, a very prominent English surgeon around the turn of the century.

QUESTION: *Mail addressed to the Burlington Instrument Co., Burlington, Iowa, who manufactured the Swiftem thermometer, is returned marked "moved". Can you advise present address?*
ANSWER: This company merged with Texas Instruments, Inc., 6002 Lemmon Ave., Dallas, Texas. They are no longer making the Swiftem Thermometer, nor will they service any.



by Mary Helen Anderson, R.N., M.S.H.A.

Program Suggestions For A Central Service Group

■ THE FALL OF THE YEAR brings renewed energy and determination to accomplish great and mighty things in the coming year. There is no better time than now to organize a Central Service group in your area. The hardest part is just getting started. The next most important thing is to keep meetings on a regular schedule, allowing almost nothing to interfere. The National Association of Hospital Central Service Personnel is offering group membership to any organized clubs or associations whose by-laws conform in essence with the by-laws of the NAHCSP. A great advantage of group membership is that individual dues are half of the dues paid by those not belonging to a group. This has been misunderstood by some to mean that if two or more persons join at the same time, there is a group rate on dues. The treasurer of the National Association, Miss Edith Pauline Johnson, has asked that the point be made clear that only those who belong to the National Association through a *member group* are entitled to the special dues rate.

How do you form a local group? Any two or three Central Service supervisors can begin to hold meetings for C.S. personnel on a regular basis. Quite naturally there comes a need for a President, a Secretary and a Treasurer. Often times the last two offices may be held by one person. There are so many problems and interesting subjects for C.S. people to discuss that the matter of program becomes quite easy. As the group grows, however, a program chairman will be the next need. Usually one of the things found most helpful in local areas is the practice of visiting the various departments and exchanging ideas. As a suggestion for a group just getting started, here are some things that might be done during the coming year.

November

Procedure book revision; members of the group bring procedure books, exchange ideas and then return to own departments to revise, edit and review procedures. A member of a university or college English department might be asked to speak on the technique of procedure writing.

December

Christmas decorations in Central Service; a contest might be sponsored by the organization (making sure that the Administration approves) and a prize awarded for the most interesting department. Of course there should be a party at this meeting.

January

Fracture equipment handled by C.S.R.; its care, storage, maintenance and control. A representative of orthopedic equipment might be asked to speak with suggestions for handling of this specialized equipment.

February

Charge systems; inventory control; records in Central Service. A member of a business office in one of the hospitals might assist in this meeting. An exchange of ideas for C.S. forms and requisitions will also be helpful.

March

Detergents used in Central Service; studies of a number of different products might be made by a committee assigned to prepare this pro-

Central Service Personnel—Please Note

■ THE NATIONAL ASSOCIATION of Hospital Central Service Personnel is sponsoring the first Institute for Central Service people.

Dates: December 9, 10, 11—just in time to see the Christmas decorations
Place: Belmont Plaza Hotel, New York City

Registration naturally is limited and it is suggested that application be made early. All Central Service Supervisors should be receiving an official application in the mail shortly. Inquiries may be made to the President, Mrs. Eva Buckingham. The program will be announced next month, but it can be said now that the committee has made every effort to bring together experts in the field of Central Service so that the Institute may be a time to be remembered.

One Administrator wisely said, "If you bring back one good idea from the meetings, we will feel that the money was well spent." We hope that there will be many, many good ideas to take back home.

Assisting the National Association in this project is the New York area Hospital Central Service Association. The Institute Coordinator is Mrs. Evelyn Roberts Woerner, Chairman of the New York Group.

Inquiries may be sent to Mrs. Eva Buckingham, Box 1634, Chicago 90, Illinois. ■

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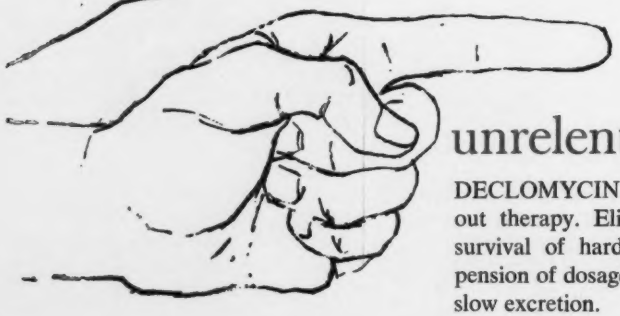

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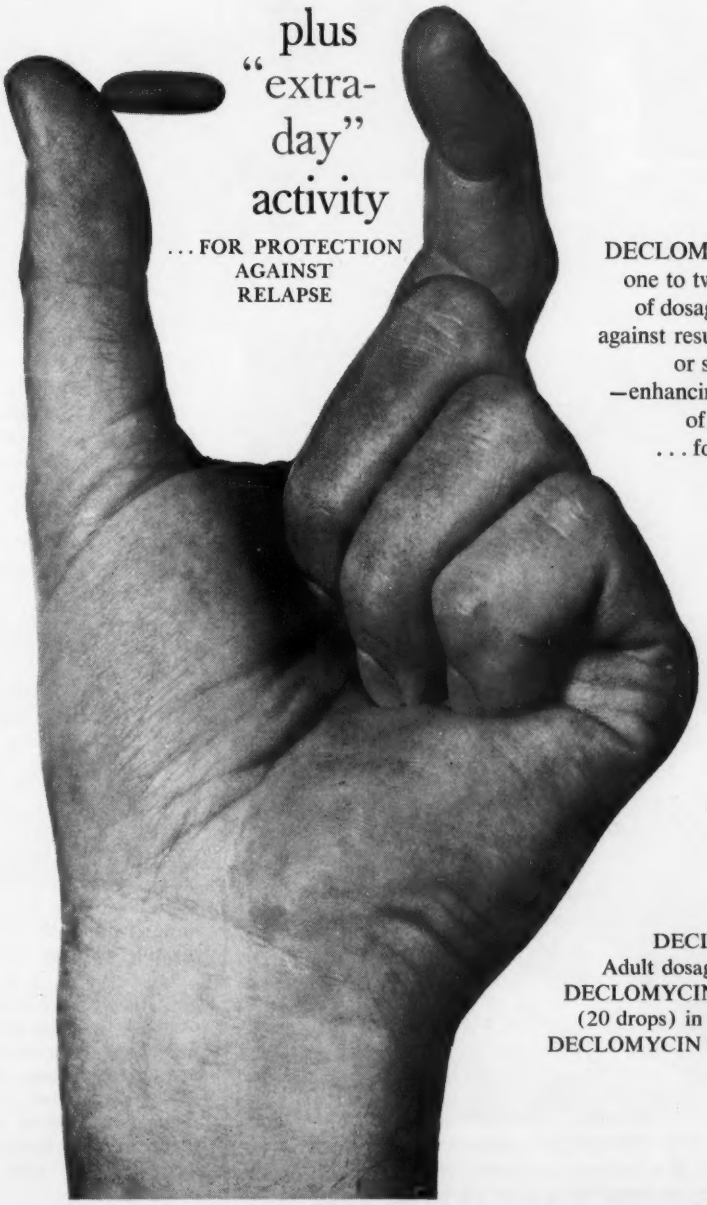

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DECLOMYCIN Pediatric Drops, 60 mg./cc. (20 drops) in bottles of 10 cc. with dropper.
DECLOMYCIN Oral Suspension, 75 mg./5 cc. Bottles of 2 fl. oz.

For more information, use yellow postcard inside back cover.

gram. Recommendations might be made to the group for proper cleaning procedures for the various materials used in C.S.

April

Time for a fun meeting. Forget the technical aspects of C.S. and meet just to get better acquainted with the others in your area who are engaged in C.S. work. Invite the husbands to an old fashioned party. This is a good time to send in your membership dues for the National Association, and to plan who will be coming to the annual meeting in May.

May

Before summer vacations, take a look at C.S. libraries. Check the magazines that contain informative material useful to Central Service. At the meeting discuss articles that have been helpful, and tell how the libraries are used in the different hospitals. Plan an article to be sent to a national magazine—such as HOSPITAL MANAGEMENT, of course—and write it as a group. Choose an idea, a procedure, a project that has been developed by a member or members of the group and share this information with all the other C.S. people in the world. Have an election of officers and close up organizational shop for the summer—except for a picnic or a party in June. ■

Let's Play It Safe

WRONG: In placing one hand on the side of a litter cart, the risk is run of bruising a hand or pinching a finger when going through a door.

RIGHT: Place both hands at the head of the cart. Guide the cart to the center of the elevator.

WRONG: With a bent back and poorly positioned arms and hands, this nurses' aide is a potential patient herself.

RIGHT: With the proper position of the hands, arms and back, the patient is moved with no strain on the patient or nurses' aide.

WASHINGTON REPORT

Continued from page 20

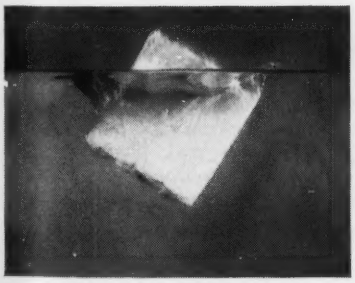
CONGRESSIONAL PROBE of hospital-medical insurance cost in the District of Columbia will begin sometime after Congress reconvenes next January. Sen. Wayne Morse, who proposed the study more than a year ago and who so far has held only one day of hearings on the subject, has already singled out Group Hospitalization (local Blue Cross) and now indicates Blue Shield is also in his sights. Blue Shield recently announced rate increases ranging up to 20 percent.

SENATE INVESTIGATION of drug costs will open on November 30. Meantime the Antitrust Subcommittee chairman, Estes Kefauver (D., Tenn.) has his staff subpoenaeing records of some 20 manufacturers and from five banks, the latter dealing with drug company ownership.

EZON T. M. 'WASH-PAK' by SEAMLESS

(MICROPULVERIZED MODIFIED STARCH LUBRICANT)

'WASH-PAK' is specifically designed to simplify the post-operative cleaning of surgical gloves. In order to facilitate drying and inspection and to prevent the gloves from sticking together while being processed add EZON to the final rinse water. EZON 'WASH-PAK' fulfills this function more conveniently than any other lubricant available. Pictures below show 'WASH-PAK''s time-saving advantages.

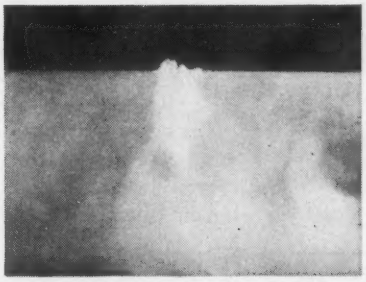


No Weighing

Just drop the EZON 'Wash-Pak' into the final rinse cycle and you're ready to go. No time-consuming weighing or measuring necessary. Each 'Wash-Pak' contains the exact amount of powder needed to condition 5 gallons of rinse water.

No Dusty Waste

Each EZON 'Wash-Pak' provides 4 ounces of micropulverized modified starch powder lubricant in a polyvinyl alcohol film pack. Dissolving rapidly in water, 'Wash-Paks' eliminate powder wastage, inaccurate measuring and starch dust in the air.



No Tedious Clean-Up

Put the lid back on the EZON 'Wash-Pak' can and you're all through. Each can contains 12 four ounce EZON 'Wash-Paks' . . . 12 cans to a case. Ask your purchasing agent to order a case today. Make your job simpler and cleaner. SR-812

EZON is the trademark of the Seamless Rubber Company for its brand of micropulverized absorbable modified starch powder lubricant. 'WASH-PAK' is a trademark of the Seamless Rubber Company.

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X-ray-Laboratory

Consideration of certain suggestions when planning a new x-ray department can eliminate much frustration, annoyance and inefficiency.

Adapting to Obsolescence in the X-Ray Department

by Tom Reinke, M.D.
Radiologist
Methodist Hospital
Lubbock, Texas

1, 2, 5—Diagnostic x-ray rooms
3—Room for superficial therapy
4—Room for deep therapy
6, 7—Present offices of radiologist
8—File room
9—Main corridor through department
10—Therapy anteroom
11—Additional file space
12—Minifilm room

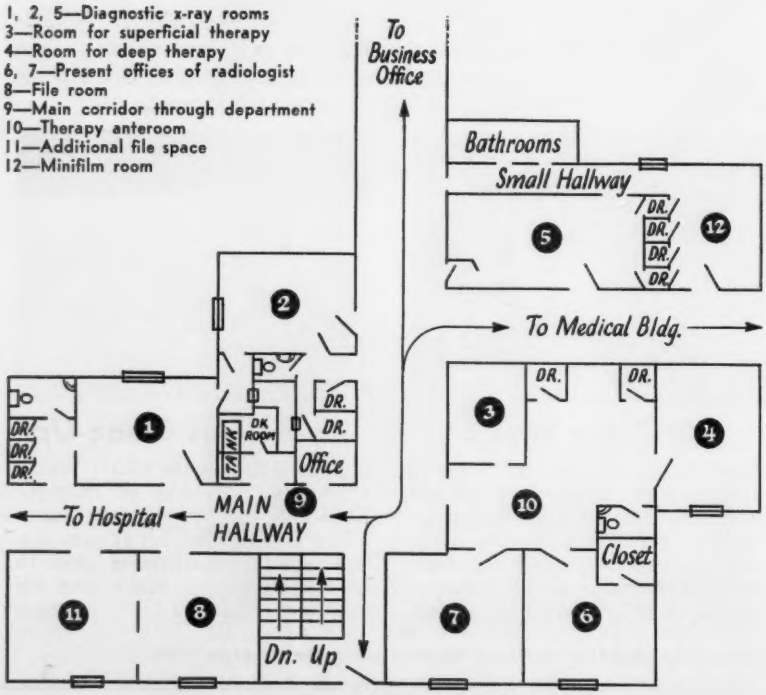

Figure 1. Original design of x-ray department.

■ SEVERAL EXCELLENT PUBLICATIONS have appeared concerning the necessity of proper planning for radiographic installations. Some x-ray companies also have good plans. They suggest necessary functinal design and ideas for various installations, but seem to neglect a few pertinent points which, for obvious reasons, should be stressed.

In any medical installation, the careful planning of the x-ray department is invaluable. Once constructed, the cost of a change is prohibitive. Mistakes can be avoided by proper planning of a design which will provide economy of operation. Wasted personnel manhours can be saved in addition to lessening the frustrations of both radiologist and technician. Too often, x-ray departments are designed by individuals who have never worked in or been around an x-ray department for purposes other than an occasional examination. Of necessity, every departmental design should be studied by a radiological consultant who is familiar with basic needs.

The design of any department must vary with the alloted space. A basic functional design will provide a centralized darkroom with a wet film viewing area, film drying space, rapid development apparatus, sorting, adequate filing room space, and radiologist's office, all readily accessible to each other to permit efficiency and service to both patient and physician. This can be accomplished by a U or H arrangement or by a plan similar to spokes of a wheel. A central area with therapy on the periphery is valuable in larger installations.

The diagram *(figure 1)* is presented to illustrate the problems that have arisen in *only one* department because of poor planning and failure to keep future growth in mind at the original design. This department originally had two diagnostic rooms (1, 2,) with a darkroom between. A superficial therapy room (3), a deep therapy room (4), a waiting room (5), examining room (6), radiologist's office (7), inadequate file room

Who Discovers the Discoverers?

"A professor can never better distinguish himself in his work than by encouraging a clever pupil, for the true discoverers are among them, as comets amongst the stars." CARL LINNAEUS

Somewhere in this mighty land of ours, a gifted youth is learning to see the light of tomorrow. Somewhere, in a college classroom or laboratory, a dedicated teacher is gently leading genius toward goals of lofty attainment. Somewhere the mind of a future discoverer—in science, engineering, government, or the arts—is being trained to transcend the commonplace.

Our nation has been richly rewarded by the quality of thought nurtured in our colleges and universities. The caliber of learning generated there has been responsible in no small part for our American way of life. To our college teachers, the selfless men and women who inspire our priceless human resources, we owe more than we will ever be able to repay.

Yet how are we actually treating these dedicated people? Today low salaries are not only driving gifted teachers into other fields, but are steadily reducing the number of qualified people who choose college teaching as a career. At the same time, classrooms are beginning to get overcrowded. In the face of this, college applications are expected to double by 1967.

This is a severe threat to our system of education, to our way of life, even to our very existence as a nation. Our colleges need help—and they need it now!

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If you want to know more about what the college crisis means to you, and what you can do to help, write for a free booklet to: HIGHER EDUCATION, Box 36, Times Square Station, New York 36, New York.

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space (8), a main hall through the department (9), tremendous lost space, and an anteroom to the therapy section (10). This basic plan was in operation for several years when it was found to be inadequate to handle the large volume of in and outpatient examinations. A decision was made to make an additional diagnostic room out of the waiting room space. An area was also allotted for a mini-film unit for routine inpatient chest screening.

The waiting room is no longer available. The patients must sit in the main hall from the hospital to the medical building. Following this change, an additional radiologist was added to the staff and the examining room was converted to an additional reading room. Space (11) was allocated for additional file room. Because of the conflict in sorting and scheduling of examinations in the file room area, additional space in the large corridor was converted into a small business office for reception of requests, scheduling of examinations, and the necessary bookkeeping incident to the operation of the department.

The secretary who had been placed in the anteroom to the therapy section has been moved into the radiologist's office because of the heavy therapy traffic. The radiographic section is now split functionally. The pass box in the hall is not readily accessible to the additional radiographic section. It creates an excess of personnel milling around in the hallways during peak working hours. This leads to criticism that personnel are standing around the halls while waiting to check their films for technical flaws prior to dismissal of the patients. Add to this the steady stream of traffic from hospital to medical building during peak working hours and confusion results. In addition, the hospital has a main thoroughfare in the middle of the department which is tightly wedged between the histological and biochemical sections of the laboratory. There is no room for expansion. To make matters worse an addition of 100 beds is planned for this 225-bed hospital.

One of the most embarrassing moments I have ever spent was while preparing to do a colon study. As the patient was being prepared for the passage of the bardex catheter, a technician opened the door of the radiographic room as several visitors were passing down the main corridor from the medical building to the hospital. The patient complained bitterly at this invasion of personal privacy. I remarked that had the man who designed the department any brains, he never would have placed a main hallway through the x-ray department. The patient replied, *"Young man, my husband designed this hospital."* Needless to say, the silence in the fluoroscopic room was deadly.

Location

An x-ray department should be accessible to surgery, emergency room and admitting room, and yet still retain the basic property of being a self-contained centralized unit. This will provide for efficient service to these facilities.

Medical Staff

The type of medical staff will necessarily alter the purchase of equipment. Naturally, a group of general men will be interested primarily in routine radiographic work and would not be interested in the purchase of angiographic or laminographic equipment and, conversely, a group of specialists on a well-organized staff would require facilities for most any type of diagnostic procedure. The patient load will alter the number of diagnostic rooms and type of equipment. This will vary with a hospital alone, a clinic alone, or with a combination operation of clinic and hospital. More dressing room space will be required with a larger outpatient volume.

Dressing Rooms

Dressing rooms should be spacious, adequate in number and size. Comfortable seating should be provided. Mirrors, ash trays and a magazine rack with current periodicals should be available for patients who are waiting for examination or dismissal.

Radiographic Rooms

Radiographic rooms should be ample in size, with a dark, adaptable hallway for use during fluoroscopy. A barium kitchen should be accessible to these rooms. Storage should be provided for the necessary linens, cones, sandbags, and other material necessary for routine examinations.

Secretarial Space

Secretarial space should be adequate with future increase of employees considered.

Floors

Drain plugs should be provided in the dark room, wet film viewing area, therapy and isotope rooms where spillage can be a hazard. This permits easy cleaning of these areas.

Walls

The walls should be of material resistant to wear and tear by stretchers, chairs or other rolling equipment. Painted walls require too much maintenance to be practical.

Storage

Storage space should be provided for wheel chairs, stretchers, and other rolling equipment when not in use. Storage for films and chemicals should be provided in an accessible area. Space should be allotted for filing cabinets.

File Room

File room space should be adequate, with the future growth of the department in mind.

Plumbing

Plumbing for the darkroom should be accessible on an outside wall of the darkroom to prevent closing the department for the occasional necessary plumbing repairs. We recently had one radiographic room in disuse for approximately one week while a wall was removed to allow access to the developing tanks for a small leak that flooded the dark room at night.

Locker Room

Locker space should be planned for technician's storage of personal effects. A place to relax during coffee break or inactive periods would also be helpful.

These suggestions are but a few of the things to be considered in radiographic planning.

Consideration of them can eliminate much frustration, annoyance and inefficiency in new x-ray departments by a little foresight. ■

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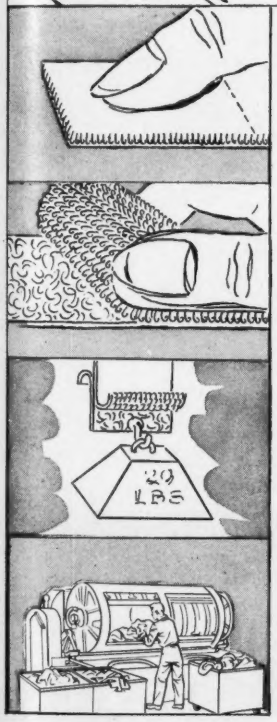

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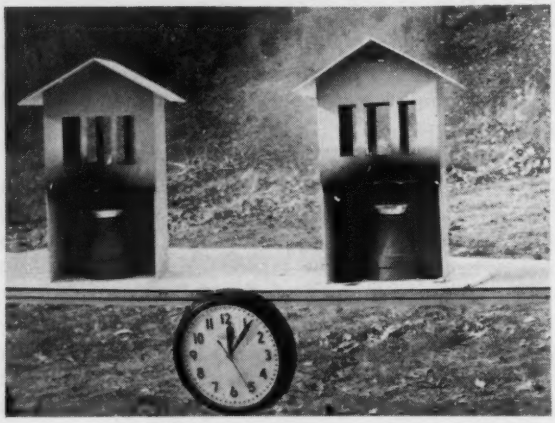
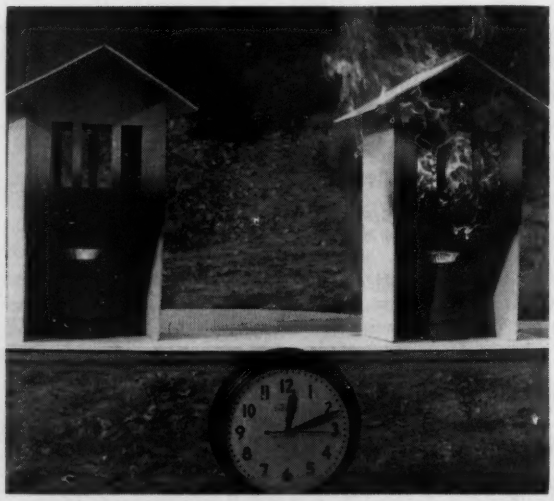
Match is set to alcohol container in plywood house on left painted with fire retardant paint.



After six minutes' exposure, there is little difference in appearance of houses, but flames are beginning to lick floor of house at right (conventional paint).



After 12 minutes, alcohol has burned out. House on right (conventional paint) is ablaze; house on left was painted with the fire retardant paint, which is intended for use on building interiors.

A Paint That Holds Back Fire

■ COMBUSTIBLE FINISHES and surface applications of paint to the interiors of hospital buildings present an extreme hazard in assisting the spread of fire, even in groups of buildings classified as "fireproof." In reality, no building is fireproof and everything that can be accomplished to retard the spread of fire is the responsibility of all concerned with the treatment and care of the patient, and the continuance of a safe patient care program.

After five years of intensive research, there is now on the market an interior paint that effectively slows down the spread of fire. It is a durable, washable interior flat finish in white and seven colors and the solvents used in it are exceptionally low in odor. It dries hard overnight under normal temperature and humidity conditions. It may be applied to any interior surface including wood, steel, plaster, composition board, and other structural materials. It is recommended for ceilings, walls, woodwork, beams and columns, window sash and trim, among many uses.

Please turn to page 124

After 20 minutes conventionally painted plywood house (right) is completely consumed. House painted with fire retardant paint is scorched, and portion of floor in direct contact with alcohol flame has burned through, but plywood house is otherwise intact and unharmed.

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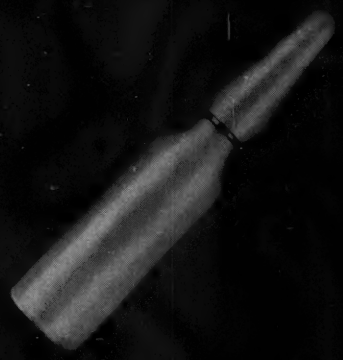

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This fire retardant paint goes on smoothly and easily with a brush, roller or spray gun. Three coats are recommended for the best results. The finish resists yellowing with age and is easily washed by hand or with machine. It may be applied *over an existing finish,* but of course the fire retardant properties are lessened as compared to an application over a new surface.

It is basic knowledge to those responsible for fire protection and safety in hospitals (and that should be everyone) that the first five minutes of any fire, and the actions taken to quell such a fire, can mean the difference between partial damage, or total disaster. After only eight to ten minutes, a fire is usually 50 times its original size.

Marshall Michael Quinn, of Chattanooga's (Tenn.) Fire Department, says:

"If a U.L. approved fire retardant paint were used inside such public buildings as hospitals, hotels, schools, auditoriums and theaters, the chance of a serious fire would be reduced dramatically."

The new paint has been passed after exhaustive tests set up by the Underwriter's Laboratories in the following categories:

Reduction of Flame Spread—To show the ability of the coating to retard the spread of fire by delaying action three coats of this new fire retardant flat were applied to Douglas fir wood decking at a spreading rate of not over 300 sq. ft. per gallon, per coat. After a 30-day exposure period, the painted decking was exposed to direct flame. Under the same burning conditions it was compared with that of the flame spread on unfinished red oak. Red oak has a classification factor of 100 and asbestos cement board zero. To be qualified as a fire retardant coating, it must reduce flame to 70 or less on the classification scale. This new fire retardant paint rated 50-70.

Fuel-Contributed Test—To determine the extent to which the paint film itself contributes fuel to the spread of fire within an area, or through a wall, the paint under discussion rated a highly satisfactory 25-35.

Smoke-Developed Test—it is well known that smoke causes panic, with the resultant suffocation, as well as proving a serious obstacle in fire fighting. This Underwriter's test measured the density of smoke developed as compared to red oak again at a factor of 100 and asbestos board at zero. The paint rated 5-45.

A test which you might easily try yourself, with the present paint products in use at your hospital, is dramatically illustrated in the photographs. Straw was placed inside both houses to determine the effects of how the paint assists the spread of fire through the base. ■

References
E. I. duPont de Nemours & Company
DuPont Magazine

MacLEAN

Continued from page 108

cies of such salts as calcium and magnesium sulfate, and calcium and magnesium carbonate, and their many combinations with elements such as silica, iron, et cetera, an alkali phosphate is usually added as boiler treatment. This accomplishes a precipitation of calcium salts as *hydroxy apatite,* which in common terminology is tricalcium phosphate *or boiler sludge.* It is a product with which all are familiar. It is a very soft, powdery material that you will find after a boiler run, wherein the treatment, if it is entirely internal, has been kept within adequate chemical equilibria to provide the optimum precipitation of the hardness salts. The salts are precipitated and of course we must depend on the boiler blowdown for the removal of this foreign material. If it is allowed to accumulate it will bake on the hot waterside surfaces and become almost as obnoxious as the harder carbonate type scale. Where silica contents of water are significant, a sufficient amount of hydroxide alkalinity is maintained to assure that the silica will not enter a reaction with the calcium and magnesium salts in any respect, either as designed precipitates from the use of phosphate treatments, or in combinations with calcium and calcium and magnesium complexes. We should note that silica type scales are those that are extremely hard to remove. They become granite hard, and indeed quartz may be deposited in boilers under certain conditions. Mr. H. E. Eigner,* in an article written for "Power" magazine in 1954, describes 25 different combinations of scale formation that may occur in boilers and their auxiliary equipment. Thus the scale control of internal treatment is predicated on a precipitation method, with the use of alkali or sodium phosphate compounds.

The other portions of normal boiler water treatment are comprised of various combinations of organic materials, which range from tanins to lignins to starches, to glucose derivatives and, with certain late developments, to other organic complexes. The function of these products is primarily to condition the precipitated sludge, caused by internal, or after-treatment, so that the sludge itself will not adhere to the metal surfaces, but will remain in suspension longer, so that where continuous blowdown apparatus is employed, a greater volume of suspended matter can be removed by this method and eventually will keep the precipitates from adhering to metal surfaces on their way to the lowest point in the boiler, which will be the tail end of a fire tube or the mud drum of a water tube boiler. It is then removed by standard blowdown.

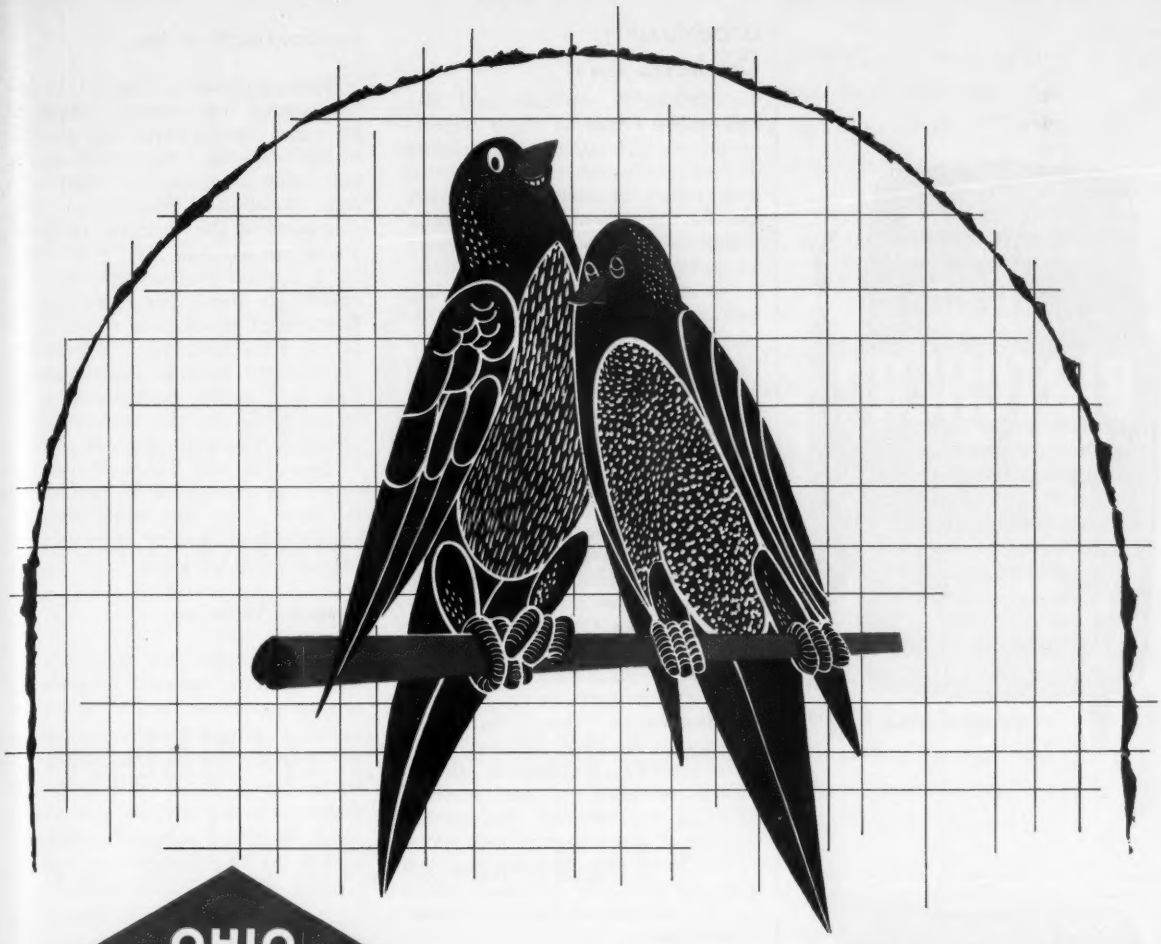
The third ingredient usually found in boiler water treatment compounding is sodium sulfite. Its function is to neutralize dissolved oxygen not removed by deaeration if such equipment is part of the system, and it functions by a simple chemical reaction. The sulfite picks up the oxygen in the water to form soluble sodium sulfate and removes forever the free oxygen, so that it cannot function in corrosive cell formation.

Administrator Adams

Be sparing of the water, Angelo, this damp weather should give enough moisture.

*Product Engineer, Dearborn Chemical Co.

This article will be concluded next month.



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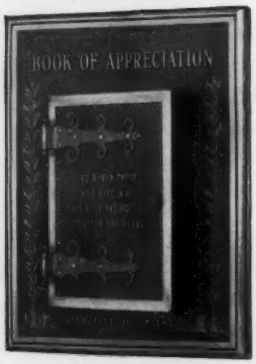

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Continued from page 45

department of medicine and vice versa. The heads of these departments would consider it a violation of their prerogatives and show that such a state of affairs is very, very bad for the patients. These reasons, though often devoid of validity, may be sufficient to cow the administrator and the board of trustees into submission to the wishes of the physicians. The beds thus remain empty because of medical compartmentalization and empire building.

Segregation

Although overspecialization and empire building are to be deplored, a certain amount of segregation must be practiced. Infectious patients, for example, cannot and should not share a room with non-infectious ones. Children, similarly, should not share space with adults, nor males with females, nor should psychiatric patients be housed with non-psychiatric. These forms of segregation must be accepted. But if, in addition, we impose further segregation based on race, creed or color, a considerable amount of wastage of beds is inevitable. And if we further segregate the rich from the poor, the increased number of combinations fosters a greater wastage.

Average Length of Stay

Hospital planning should take into account the average length of time that doctors keep their patients in the hospitals. This is particularly noticeable in obstetrics. There is a wide variation in practices in various parts of the country. In south Texas the average stay is 3.5 days for a normal confinement, in Chicago it is about five days and in Montreal, Canada it is seven days. Simple arithmetic determines quickly that twice as many hospital beds are needed in Montreal as in Texas to handle the same number of births. The same number of beds in Montreal and Texas would result in a wastage of 50 percent in the latter place. But would there be a difference in quality of care? Who can say?

Seasonal Variations

We have noted that there has always been a seasonal variation in occupancy of hospitals in the United States. During the first 35 years of this century there were some obvious reasons for it. But today the reasons, though obvious, are not so valid. How this seasonal occupancy affects the per patient day cost of hospitalization is shown dramatically in the tables taken from our study of How's Business[12] for the years 1957 and 1958 *(graphs 1-3)**.

During periods of low occupancy, the hospitals show a sharp rise in expenses per patient day (or per occupied bed) which may actually result in a financial loss per patient day. Hospitals have also noted a general slowdown on week ends and on holidays. ■

---

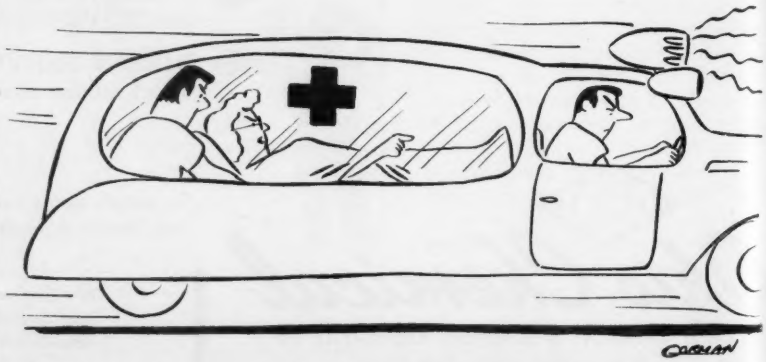
[9]Hospitals. Journal of the American Hospital Association. March 1, 1957. p. 35

[7]M. I. Roemer and M. Shain; Hospital monograph series no. 6, hospital utilization under insurance. American Hospital Asociation, Chicago, 1959. p. 14.

[11]Even so, the American College of Obstetricians and Gynecologists recommends (Manual of Standards, March, 1959. p. 5) that "the annual rate of bed occupancy should not exceed 70 to 75 percent."

[12]Published monthly by HOSPITAL MANAGEMENT. On Sept. 15, 1959 more than 1500 general, non governmental hospitals participated.

This study will be concluded in the December issue.



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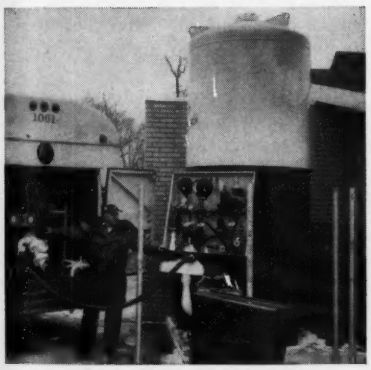
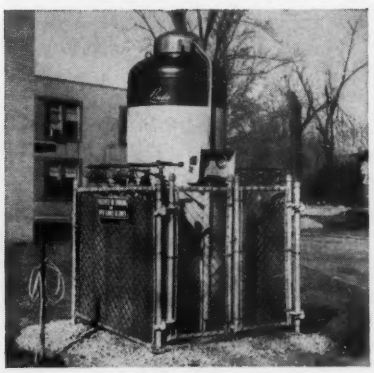


Surprisingly compact, this 90 VCC unit holds 90,000 cu. ft. of oxygen. It's a relatively small package because at atmospheric pressure liquid oxygen in its gaseous state would require 862 times more storage space.



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Continued from page 42

so that when grounded it will draw a current of two milliamperes and plug into outlets served by isolated system so as to check the green and red lights and buzzer.

Test procedures should be scheduled weekly for emergency generating equipment. This is accomplished by opening the high-voltage load break switch in the case of primary service, or the main breaker if the hospital receives secondary service. This simulates a complete utility failure, which should cause the automatic transfer switch to operate, starting the engine driven generator, which will supply service to all critical feeders. Time of the transition, as well as the functioning of various relays and breakers, should be noted, if automatic control is used for dropping out non-critical circuits. Allow emergency set to operate for five to 15 minutes to assure that engine and generator are functioning properly. It would be well to schedule an outage with the utility about twice a year; let them pull the primary disconnects at the pole to make sure that your emergency generating equipment will start up from the operating of the time delay under-voltage release device on the main breaker of the hospital.

Since one of the important features of an emergency generating set is to restore service to critical circuits within eight to ten seconds, it is essential that the engine starts quickly. Emergency generator sets should be in a heated room so that engine and generator do not start up cold.

While discussing services, and maintenance of services for critical areas, such as the operating and delivery rooms, something should be said regarding conductive flooring required to drain off electrostatic charges. Here again the equipment is no better than it will prove out by test. Methods of testing are described in the NFPA pamphlet No. 56. Again a card record of the test data should be kept on file. Several key personnel should be familiar with the electrical system.

Adequate identification, often left to installers and operators, is many times neglected. It is extremely important that the entire system be completely identified and that it coincide with the electrical print of the building wiring, which should be mounted on the switchroom wall. Identification of switchgear, control apparatus, and all important components should be made when put in service.

Identification of newly purchased and installed equipment, circuits and panels on the electrical prints is equally or more important. It should cover power and lighting feeders, switchgear, motor starting apparatus, control stations and all driven equipment. The identification should leave no room for doubt in the mind of the person pushing buttons, working on driven equipment or on current carrying parts that are supposedly de-energized.

Switchrooms should not be storage rooms for drugs, chemicals, laundry or janitor supplies. Keep the switchrooms clean and completely accessible at all times.

Personnel safety measures in regard to electrical facilities and equipment include education, safety rules, inculcating personal safety habits, safe operating procedures and a hospital policy. Safety is most important in the electrical facilities. ■

Before you Paint Make Adequate Preparation

by Emile F. Sanford, Sr.

■ PLASTER WALLS are primed for the purpose of providing adhesion of subsequent coats to the surface and to inhibit or prevent undesirable chemical and physical reactions occuring at the material surface and to stop suction on porous surfaces, thus preventing saponification. Primers are used not only to insure proper adhesion between wood or metal surfaces ???? the final coat, but to also act as rust and corrosion inhibitors.

Exceptions would be first surface applications of material such as a primer sealer; in a two-coat system where the primer sealer acts as a combination first coat and sealer, than as a primer. Acetic phosphoric metal preparations or treatments, which leave no film, are used to act chemically on the surfaces of bare, clean metals to prepare them so there will be less tendency to corrode. Then, and only then, will additional coatings adhere, both initially, and after long time exposure.

The following list is representative of acceptable prime, and primer sealer materials for use today:

Wood new and old: alkyd white
Undercoater applied to new plaster: polyvinyl acetate
Bare metal (free of oil): zinc chromate or red oxide lacquer
Masonry floors: desron
Metal furniture: red oxide lacquer
Wood furniture: clear lacquer primer
Machinery: red oxide lacquer or zinc chromate.

The following for finish coats are suggested.

Plaster walls: alkyd flat or semi-gloss (in services areas only)
Wood Work: alkyd semi-gloss
Metals: automotive synthetics or lacquers
Masonry walls: vinyl acetate
Concrete floors: devron
Machinery: automotive lacquers or synthetics

Checking of exterior paints, among other factors, may be due to the application of relatively hard finishing coats over soft primer or underlying coats of material. Such conditions exist either when the primer or other undercoats are too rich in oil; when not enough time has been allowed for undercoats to dry properly, or when the finish coat lacks elasticity and possibly any combination of these factors.

Under the influence of temperature changes, the paint film contacts and expands. If the top, or outside coat, is not elastic enough, it cracks. The remedy is to allow the priming and other undercoats to dry hard and firm before applying the finishing coat. In warm, dry, clear weather, shorter time may be allowed than in cool, moist or cloudy weather. Blistering is caused by moisture entering the material from behind. This entrance of moisture may be overcome by backpainting and providing adequate vapor barrier or seal on all exterior walls and surfaces.

When paint is applied to old finishes on plaster walls, the follow-

Mr. Sanford is foreman, paint division, Department of Engineering and Maintenance Baptist Memorial Hospital Memphis, Tennessee

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☐ 51. 25 Years of Ambulant Patient Care—H. Weinberg
☐ 52. Hospital Library Service—H. J. Gartland
☐ 53. Prepaid Medical Care Plans for Senior Citizens—T. P. Weil
☐ 55. Handling Narcotics in Federal, State, County, City Hospitals —G. F. Archambault, Ph.C., LL.B., D.Sc., A. W. Dodds, Ph.C.
☐ 56. Eligibility for Free Hospital Service—R. N. White

(Continued on Following Page)

ing procedures are recommended. Remember, the proper preparation is paramount to a successfully completed job.

1. Tape the baseboard and remove all hardware. Tape all hardware that is not removable and cover the floor with drop cloths.
2. Wash walls with strong detergent solution, rinsing thoroughly so as to leave no chemical film on wall surface *(see step 9)*
3. Sand walls with No. 100 grit production sandpaper deep enough to break the film of the old painted finish.
4. Rake out and spackle all indentations in walls and ceilings, using one of the new synthetic spackling compounds. Make sure it is not sour.
5. Sand all spackled areas and prime these individually.
6. Prime entire surface with polyvinyl acetate material; use roller, brush or spray.
7. Apply first coat of color to walls, ceiling and trim.
8. Apply final coat of color.
9. If plaster walls are new, wash new plaster with a solution of white vinegar and follow the same procedures, as listed above.

Patient rooms, to be continually maintained, require painting on a minimum frequency of every three years; five years, as a maximum for other areas. Master plans, or schedules, showing every room number or name, color code numbers, painting and papering schedules, with starting dates, and completion dates, will assist administration, nursing, admissions, and housekeeping. Upon completion, all areas are dated, and the color data is filed for future reference.

Quality material and workmanship in painting procedures will insure appearances and prevent undue deterioration of your hospital buildings and their equipment. ■

In Hollywood a movie censor phoned a studio official about some stills showing a girl in a rather revealing costume.

"They're OK if that's an evening gown," said the censor. "But if it's a nightgown, the picture's out!"

Correction

In the October issue, page 72, under the *"Suggested conditions to be used as a guide in awarding contracts"*, the closing sentences should read as follows:

All contracts shall be formalized with the issuance of a purchase order and/or standard A.I.A. contract form. The contract documents shall then be signed by the administrator or other person so authorized by the governing body of the institution. In the event that the total work to be done is of a minor nature and does not exceed an approximate amount of $100.00, these bidding procedures may be waived if deemed advisable by the departments of purchasing and engineering.

We apologize for the errors in the October issue and urge you to include this corrected material before you file this article for future reference.

Reprint Editor, HOSPITAL MANAGEMENT
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Staph. aureus
strains FI 1,
Ma 1, 101, 3B/3C,
47/53/77, 80/81

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Most epidemic staphylococcus strains resistant to other antibiotics readily respond to TAO.[1,2,3] As two representative studies report:

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Significant fact: TAO is de-acetylated in the patient into at least 7 biologically active antibiotic substances. Each of these (in addition to TAO) is effective against common causative pathogens, including resistant strains of **Staph. aureus.**[4] This unique TAO "Starburst" suggests **an entirely new concept of antibiotic effectiveness;** it may indeed be a reason for TAO superiority. To wit:

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Other TAO forms available: TAO®-AC—TAO analgesic, antihistaminic compound. **TAOMID®**—TAO with triple sulfas. **Intramuscular or Intravenous**—in clinical emergencies.

References: 1. Leming, B. H., Jr., et al.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 418. 2. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958. 3. Isenberg, H., and Karelitz, S.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 284. 4. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959.

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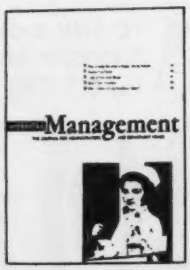

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SCHOENFELD

Continued from page 52

6. The use of higher authority to settle difficulties arising in the organization (the "exception principle" of management).

Motivation

The fourth function is that of motivation. This is the stimulation of the human element toward the particular desired goal. This is done generally in three basic ways:

1. By inspiration — this is considered the best method.
2. By irritation — this has a purpose, but is not lasting.
3. By punishment—this may accomplish its point, but is poorest because it is based on fear which, in itself, degenerates an organization.

Since every organization is composed of people, this technique must be thoroughly understood and properly used by the progressive superior. He must understand that motivation is based upon the recognition and fostering the basic drives of human beings. These drives include:

1. The instinct of self-preservation. This includes the need for food, clothing and shelter.
2. The instinct for procreation. This is a sexual drive — the drive that develops the family and makes up into a community.
3. The drive for the satisfaction of basic job wants. This, discussed in previous detail, reveals itself in the worker's desire for status, security, good supervision, adequate compensation, opportunity to progress, and a good standard of living for his family.

The modern supervisor must develop a positive technique of motivating people if he and his organization are to be successful. The many methods used throughout our country today fall into two general classifications. These are:

1. *Financial incentive.* This is the most easily understood and installed, and yet one of the most difficult for nonprofit voluntary organizations. This method includes salary increases, special bonuses, prizes, overtime, free employee benefits. It is, however, not necessarily the most successful in motivating people.
2. *Nonfinancial incentive.* These include medals, uniforms, service awards, personal publicity, competitive production or service graphs, free educational opportunity. With this type of incentive, the supervisor has the opportunity to develop personal rapport and friendship with his employees, his colleagues and supervisors. Proper orientation and training also acts as an effective incentive for doing a better job because of better understanding. We have been told that the knowledgeable worker is the best worker and this has been demonstrated amply in the industrial organizations of our country.

The supervisor or executive, therefore, plays a major part by developing his own personality as a leader. The force of his example can have a major effect upon his organization. His interest in his subordinates and his desire to make their work environment as pleasant and attractive as possible can benefit all concerned.

These are some of the factors and functions that make for production in a hospital organization. The effective use of these factors of production will insure the efficient management of hospitals. This will provide, in turn, the best possible service to the patients at the most reasonable cost. ■

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Management Aids

1101 — Protection of Floor Matting

■ AN 11 by 14 inch card giving instructions on the care of floor matting has just been produced by American Mat Corp. Intended for posting in maintenance departments, the card covers 14 "do's" and "don'ts" on the preservation and maintenance of mats.

1102 — Primer Sealers

■ "ALL ABOUT PRIMER SEALERS" a new booklet offered by William Zinsser and Company. This booklet outlines the purpose of paint primer sealers, the three basic types available and their application to various surfaces.

1103 — Indexing Microfilmed Records

■ RECORDAK CORP. has made available a booklet which simplifies and explains the best methods for indexing microfilmed records.

1104 — Offset Printing

■ A BROCHURE on finer offset reproduction for businesses and offices of all types, has been announced by Photostat Corp. The booklet describes in detail the newest line of offset duplication equipment. Close-ups of new design concepts of the equipment are featured with explanatory text. Accessories that can be used for special applications are also described. In addition, the brochure outlines which models are best suited to what needs.

1105 — Safety Check List

■ CONTINENTAL COFFEE CO., is offering a check list, which reviews total food service operation by working areas from the receiving room to the dining room.

1106 — Visual Projection Equipment

■ PROJECTION OPTICS CO., INC., published a folder, "How to Win Attention and Influence Audiences", which is offered free to those interested in the use of visual projection equipment. The folder contains a series of suggestions on the use of opaque projectors in lectures and other group communications, a projection table which translates distance into screen size, a complete description of the Opa-Scope, and a technical breakdown of the unit.

1107 — Diesel Electric Generating Set

■ THE ENTIRE LINE of generating sets by D. W. Onan and Sons, Inc., is described and illustrated in a folder recently issued. These sets provide a dependable continuous source of electricity for all types of rugged operations. And in emergency power applications, where low-volatile diesel fuel is preferred over gasoline. These electric plants provide quick-starting auxiliary power for hospitals and institutions. Specifications and illustrations of these sets, in sizes ranging from 3,000 to 6,000 watts (air-cooled) and from 10,000 to 230,000 watts (water-cooled) are included.

1108 — Maintenance Manual

■ A REFERENCE GUIDE to the modern and efficient techniques for building maintenance is offered by Johnson's Wax. Divided into 12 sections, the manual is a comprehensive and detailed summary of the most up-to-date developments in methods, materials and products for solving the day-to-day problems faced by building maintenance personnel.

1109 — Chemical Index

■ THE NEW 1959 Fisher Chemical Index describes 7,000-plus chemicals in one easy to use alphabetical listing. The index gives structural formulas, formula weights, melting and boiling points, color index numbers. The index also contains instructions on how to store chemicals; defines the various purity grades; and reproduces in miniature a chart of emergency treatments for laboratory mishaps. The book is free to qualified laboratories.

1110 — Floor Styling Handbook

■ AZROCK FLOOR PRODUCTS offers a handbook on floor designs showing the home-owner, decorator, builder or architect how to plan a floor for any type or size of room. It gives information on using color and design effectively in floors, and covers the advantages of the tile and the many places where this flooring may be installed. Color charts on five of the flooring styles picture the wide range of colors and stylings.

1111 — Equipment Catalog

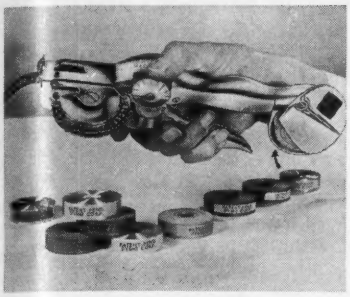
■ COLE PARMER Instrument and Equipment Co., is offering a new, fully illustrated scientific equipment catalog of selected items for general research, production, and quality control, biochemistry and clinical laboratories. The 200-page volume indexes numerous new instruments, appliances and equipment and provides complete specifications and information.

1112 — Lamps

■ A BROCHURE of lamps most suitable for commercial and institutional application has been issued by Lightolier, Inc. This selection details table and desk lamps, wall and pin-up lamps, floor lamps and floor-to-ceiling electrical columns, all chosen from a standpoint of economical price, good lighting design, practicality, sturdiness and ease-of-maintenance. ■

Product News and Literature

1113 — Embossing Machine



■ EMBOSSED labels can be made on the spot with this precision made instrument. This machine weighs 26 ounces. A wide variety of half-inch tapes are available. When label is finished it can be attached easily because of its pressure-sensitive adhesive backing. Priced at $34.95, further information available. (Dymo Corporation)

1114 — Paper Louvers

■ A SPECIALLY treated paper for vertical blind louvers. The paper is of off-white mottled texture, disposable and quite inexpensive, making it ideal for hospital contagious wards, where replacement of materials is often necessary. One of the most important features of this paper is that it is flame resistant. (Vertical Blinds Corp. of America)

1115 — Paste Pen

■ THESE new paste pens come loaded with 5,000 dots of strong adhesive. May be used as a "liquid stapler" for making attachments to patient or administrative records or a neat paster in arts and crafts therapy. Paste is absolutely nontoxic. Available at $1.49 each including refill. (A and A Sales).

1116 — Disposable Toothbrush

■ THIS TOOTHBRUSH is designed to be used once and then thrown away. The toothbrush is already charged with dentifrice and hermetically sealed in a sanitary package. The bristles resemble those of a conventional toothbrush and have the rigidity needed for effective cleaning and removing of food particles but are flexible enough to massage the gums without irritation. The brush and dentifrice are subjected to sanitizing procedures during packaging and unit has a shelf life of a least 18 months. The cost to volume users will be as low as 3½ cents each. (Flex-I-Brush Corp.)

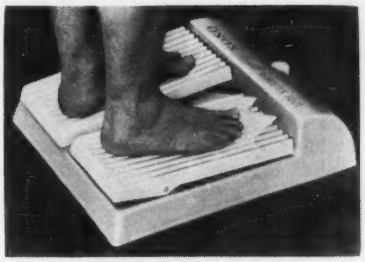
1117 — Christmas Window

■ A SPECIAL do-it-yourself Christmas window to bring the spirit of Christmas to patients confined to the hospital at this special time of year. Designs are lithographed on special paper and need only to be oiled with vegetable, baby or mineral oil and colored with crayons. The designs are transformed by this process into "stained glass" windows, effective both day and night. The windows feature 24 "panes" (nearly 16 sq. ft.) that can be trimmed or arranged to fit any size window or windows. Price $2.00 postpaid. (Stained Glass Craft)

1118 — Casement and Drapery Fabrics

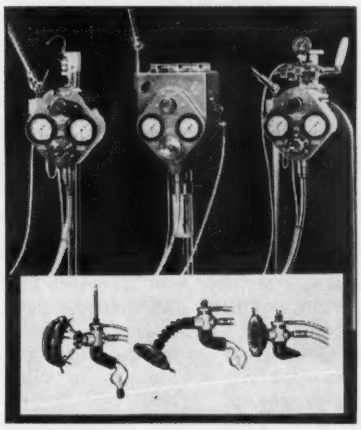
■ A NEW, permanently non-flammable fabric, readily serviceable for washing and drycleaning. The fabrics have good resistance to shrinking and sagging, good light stability and are rot and mildewproof. These fabrics also have excellent resistance to gas fading. (Virginia Fibre Corp.)

1119 — Footsprayer



■ A NEW FOOTSPRAYER to dispense a solution for the prevention of athlete's foot. When bathers step on the treadles, four jets spray feet and toes thoroughly. The footsprayer is made of fiberglas and high-density polyethylene with a non-skid rubber base. It is sanitary, easy to clean and service. It holds a gallon of solution, sufficient for more than 3,000 treatments. (Onox, Inc.)

1120 — Respiration Units for Infants

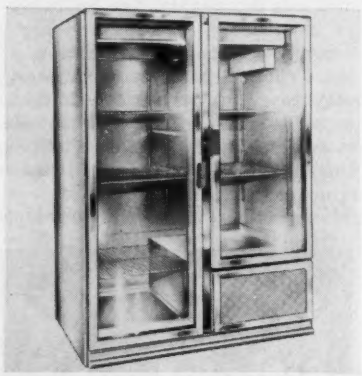


■ THE THREE new units feature minimum dead air space, flexible small bore main tube, miniature manifold and flex tube designed to be used in any position, reduced maximum flow and interrupted nebulization. For adaptability 3 sizes of infant masks are supplied with each unit. (Puritan Compressed Gas Corp.)

1121 — Autoclavable Dinnerware

■ THIS PLASTIC dinnerware is designed to meet the specific requirements of hospital and institutional care of the emotionally disturbed, children and aged, as well as contaminant and infectious cases. According to the company, the line features safety and savings through unbreakability; resistance to the staining effects of coffee and tea; ability to stand repeated autoclavings, boilings, and chemical sterilization. Items now available are stacking cups, soup bowls, vegetable dishes, dessert plates and saucers, offered in five colors. (Zylon Products Co., Inc.)

1122 — Glass Door Refrigerator

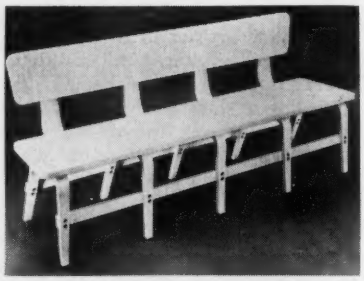


■ A NEW LINE of hinged glass door reach-in refrigerators that provide up to 50 percent more glass area than previously available on similar models. The new glass door features a welded, thin frame of precision extrusion and multiple pane, non-fogging glass units. Also a edge-mounted friction latch, and pin-type lift off hinges to allow door removal without tools or removing hinges. An exclusive air circulating system prevents air from hitting glass area eliminating fogging of glass while maintaining even temperature. The glass doors are available on all model reach-in refrigerators from 11 to 90 cu. ft., in stainless steel or white enamel, in self-contained or remote styles. (Jordan Commercial Refrigerator Co.)

1123 — Water Service Pitcher

■ PITCHERS provide hospitals with a safe, sanitary, disposable water service for each patient. Pitchers are sturdily constructed; quart size; holds water or other cold beverage for long periods of time. Contents are safeguarded from any foreign airborne bacteria by a tight-fitting lid that snaps securely into place. Pitchers eliminate time-consuming washing-and sterilizing. Storage space is conserved, because pitchers can be nested. Pouring spout has been designed so that liquids can be dispensed at a normal rate or a drop at a time. (Dixie Cup)

1124 — Outpatient and Clinic Bench



■ THIS BENCH features maintenance free plastic laminates on all wearing surfaces. The back supports and legs are of electronically laminated curved veneers with self leveling glides. This bench will seat four persons on its 72 inch seat. Available in 3 durable wood finishes and a choice of 3 patterns. (National Hospital Furniture)

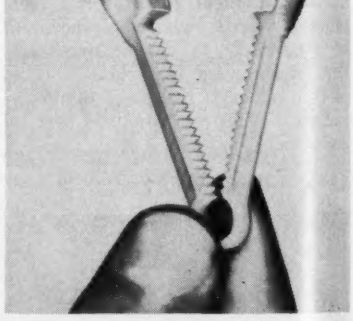
1125 — Combination Lamp

■ THIS is a new 3-way lamp that balances incandescent, and fluorescent light in one fixture. Either type of light can be used individually or in combination for comfortable illumination. The lamp has light output of 500 foot candles at 12 inches using 60 watt bulb and one 22 watt fluorescent tube. It adjusts easily to any position and stays put. It can be raised, lowered, tilted or turned to any angle to put light where you want it. Has 2 extension arms, 360 degree sweep and 45 inch reach. Available in three colors. (Luxo Lamp Corp.)

1126 — Tinting Glass

■ A DELICATELY balanced alkyd based formulation which permits flowing a transparent color coating directly onto window glass in position. The application method is fast and clean, does not interrupt normal business operations, bonds tightly to window glass and may be washed in the standard manner without scratching and so forth. It is available in 8 colors. The finish dries in about 30 to 40 minutes. According to tests made by company the tinted glass eliminates up to 100 percent fading from sunlight striking furniture and fabrics. Glare which causes eye fatigue can be reduced up to 95 percent. (American Glass Tinting Corp.)

1127 — Umbilical Cord Clamp



■ A SMALL, lightweight clamp made of nylon. The clamp fits any size umbilical cord and maintains constant pressure. It grips blood vessels together over a safe quarter-inch area, eliminating hemorrhaging and seepage. The wide opening permits easy insertion of the cord, and finger rests help steady the clamp so it will not twist or turn in the hand during application. Designed with serrated edges and a catch-type closure, the clamp locks easily and will not slip off or release. It is usually removed after 12 hours. (Hollister Inc.)

Continued from page 38

As medical science progresses, a new fall risk has developed. It is already at least as widespread as the falls from bed. Over the last two decades, medicine became more and more conscious of the fact that bed rest represents to some extent a risk to the health of the patient if it is overextended. Bed sores and general debilitation can be quite harmful, not to mention the psychological effect of protracted and enforced confinement to bed. More and more the physician insists on ambulation of patients at a time during their sickness or during their confinement after childbirth, when only a few years ago nobody would have dreamt of allowing them out of bed. Not so long ago, the doctor's order of out-of-bed privileges was the first definite harbinger of the patient's recovery. If a patient was allowed to leave his bed, and if he or she fell accidentally, the hospital's responsibility in the past was *prima facie* somewhat relieved. There was a certain practical assumption that the hospital could not very well count on having as severe a risk on its hands as if the patient would have been bed bound. However, this rule of thumb does not apply any more. Out-of-bed permission is no longer in all instances a privilege of the convalescent, but part of the treatment of acutely sick or weak people. The fall accidents of patients sliding from chairs or wheel-chairs, hurting themselves in the bathroom, or just collapsing while taking a few steps within their own room, prove that progress in medicine in this respect results in additional responsibility for the hospital. Helping, guarding and securing the ambulatory, still sick or weak patient is an aspect of nursing care which may have been practically unknown a decade ago. It even extends to the responsibility of protecting such patients against falls from bed. In former years, out-of-bed privileges more or less automatically eliminated the necessity of attaching siderails. Today, it may very well happen that a patient is directed to move about to some extent and is, nevertheless, in as much need of special protection once he is in bed, as another patient who is completely bed-bound. The severe problem arising from the chronic shortage of nursing personnel is even more intensified by this aspect of modern medicine. Maybe the day has arrived when for the proper protection of patients the job category of "patient walker" should be added to the hospital nursing staff.

Conclusion

The risk of a sick person to fall by accident is innate in his condition of failing health. The hospitals should be aware of this ever present subjective risk. All they can and should do is to observe the normal precautions for the elimination of objective fall hazards. Beyond this there remains the problem of protecting the patient against possible falls from bed and the new problem of safeguarding the sick and weak person who ought to be ambulatory as part of his treatment and has to be guarded because of sickness and frailty while moving about. All mechanical devices — as ingenious as they may be — have not yet replaced the best time honored safety device of the hospital: the human and humane technique of good nursing care. ■

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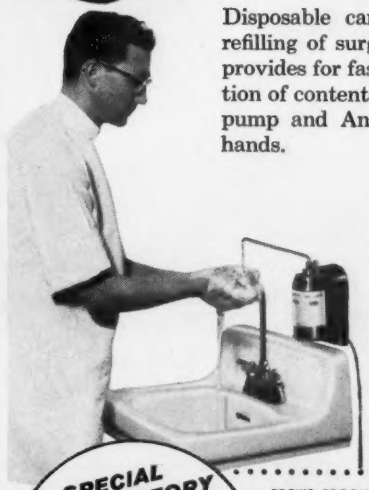
Foot-operated
SOAP DISPENSER SYSTEM



Disposable cartridge puts an end to messy refilling of surgical liquid soap containers and provides for fast replacement with no adulteration of contents. A touch of the Ped-O-Flo foot pump and Anasep soap is instantly in your hands.

ANASEP IS KIND TO YOUR HANDS

Fortified to surgical scrub standards with G-11*, Hexachlorophene. Continuous use of Anasep leaves a bacterial mantle of protection on the skin after rinsing. The low pH aids in keeping hands soft and smooth even after repeated washings. *TRADEMARK OF SINDAR CORP.

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Please send me one PED-O-FLO dispenser and case of 8 ANASEP cartridges—a $20.50 value, now only $13.50.

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BILL ME ☐ MY CHECK ENCLOSED ☐

CAMPBELL

Continued from page 49

rious floor maintenance materials such as floor waxes, sealers, cleaners, floor paints and floor maintenance machines.

Betz—one of the larger consulting laboratories for industrial water problems has one entitled "Industrial Water Conditioning." This handbook contains an excellent account of approximately 38 different treatment methods commonly used to remove impurities or to condition water for a specific specialized use. It also gives detailed procedures to follow in performing tests to identify approximately 25 of the common impurities found in water. This handbook is a valuable reference for the library or bookshelf of every engineer and can be obtained at a small cost. Even though the Company does manufacture and sell water treating compounds, the book is completely free from advertising matter.

4. *Government Publications.*

The Federal Government operates a large printing office which publishes information on almost every subject in the world. A large amount of this material is useful to the hospital engineer and others who are concerned with maintenance of buildings and equipment. Most of these publications are available at small cost to the public through the Government Printing Office. In fact, the Superintendent of Documents at the U. S. Government Printing Office will place your name on the mailing list to receive notices of new reports which are being printed. There is no charge for your receiving these notices.

Illustrative of the type of information which can be obtained from this source are these publications.

Selected Bibliography—The first is a Bibliography on Building Construction and Maintenance in which are listed the titles of thousands of articles on this subject varying from air conditioning to termite control. All of them may be ordered from the Government Printing Office.

Here are some of the actual articles which have been obtained from this source.

a) Water Distributing Systems for Buildings—describes the different piping requirements and water requirements for various buildings.

b) Structural Properties of Conventional Wood Frame Construction for Walls, Partitions, Floors, and Roofs.

c) Strength of Houses Report—discusses the strength requirements for the various component parts of buildings.

d) Plumbing Manual—describes the design and installation of plumbing systems for federal agencies. It might be of interest to see how this compares with your city code.

e) Live Loads on Floors in Buildings.

f) Fire Resistant Classifications of Building Constructions.

g) Remedies for Building Condensation Difficulties.

h) What to Do About Condensation.

i) Condensation Problems in Modern Buildings.

5. *Articles from Trade Publications.*

A book entitled "Plant Engineering Practice" is a carefully selected collection of articles which have appeared in one of the well-known trade magazines during the past few years. These articles were originally written by some of the top maintenance engineers in the country.

This book contains approximately 200 well-written articles covering many different maintenance prob-

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Dundee's extra-wide SUPER-SELVAGE provides greater tensile strength than other hemmed or turned selvages . . . eliminates puckering and possible retention of washing-chemicals. The wide CAM BORDER permits better property marking. And remember, when you specify Dundee . . . your linen source *knows* you're particular!

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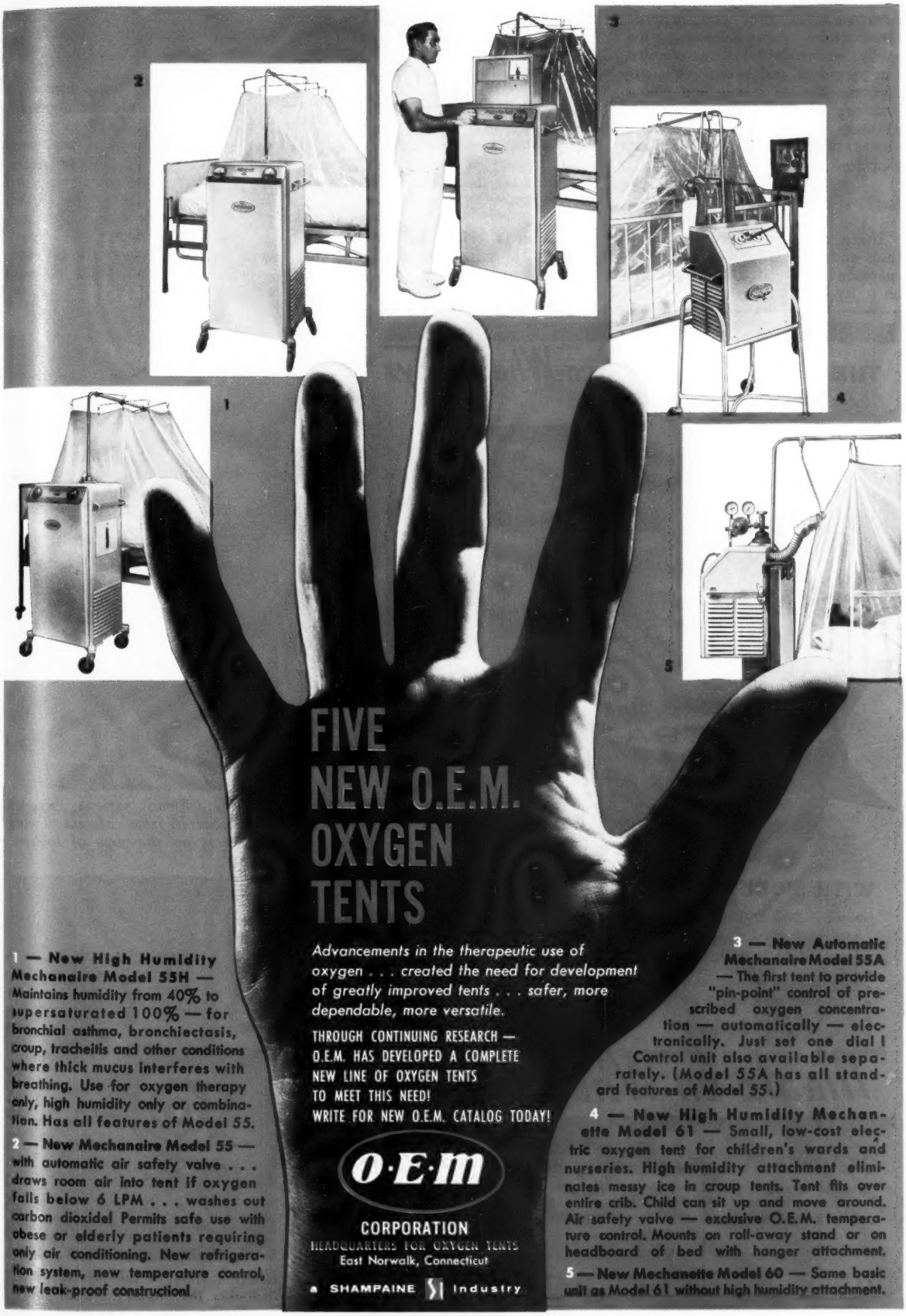
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Advancements in the therapeutic use of oxygen . . . created the need for development of greatly improved tents . . . safer, more dependable, more versatile.
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3 — New Automatic Mechanaire Model 55A — The first tent to provide "pin-point" control of prescribed oxygen concentration — automatically — electronically. Just set one dial! Control unit also available separately. (Model 55A has all standard features of Model 55.)
4 — New High Humidity Mechanette Model 61 — Small, low-cost electric oxygen tent for children's wards and nurseries. High humidity attachment eliminates messy ice in croup tents. Tent fits over entire crib. Child can sit up and move around. Air safety valve — exclusive O.E.M. temperature control. Mounts on roll-away stand or on headboard of bed with hanger attachment.
5 — New Mechanette Model 60 — Same basic unit as Model 61 without high humidity attachment.

For more information, use yellow postcard inside back cover.

lems such as sites and layouts; construction; housekeeping and safety; materials handling; maintenance; paints and protective coatings; mechanical power and piping systems; electric power; lighting; utilities; heating ventilating and air conditioning; instrumentation; shopwork.

Institutes and Workshops

There are many excellent institutes and conferences for engineers sponsored by various organizations, on a local, state, regional and national level. The chances are that if you look around a bit you will find several such meetings being held each year within easy driving distance of your home.

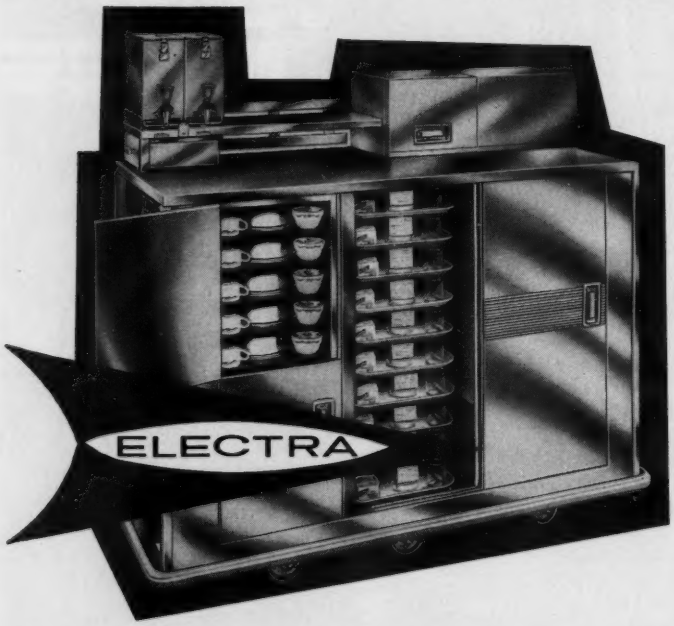
And then there are still other sources of information and help such as local meetings of the American Society of Heating and Air Conditioning Engineers and many similar technical organizations.

Engineers in office buildings and industries in your locality are frequently able to give very good suggestions on solving a particular problem for they have the same difficulties with their elevators, boilers, air conditioning units, heaters, and piping systems that you have.

The local utility companies and service companies are usually very cooperative and helpful in giving suggestions and help on problems which are similar to the problems which they encounter.

These are just a very few of the many sources of help which are available to you. Don't wait, however, to start cultivating these sources of help until an emergency problem arises. ■

THE ALL NEW *Meals-on-Wheels System*



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No other mobile food service offers you so many advantages including:

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- Two B-6 beverage containers.
- Toaster outlet.
- Utility drawer.

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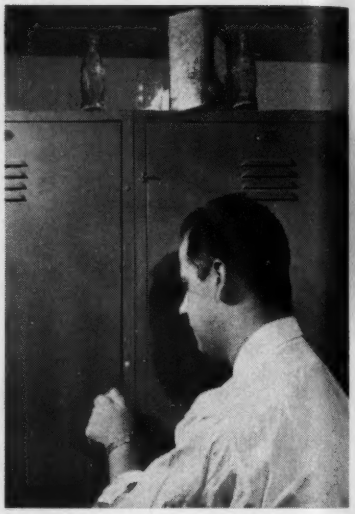
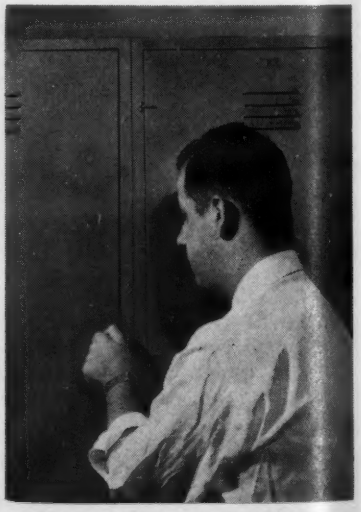


WRONG: Some serious injuries have occurred from careless placing of objects on the tops of lockers.



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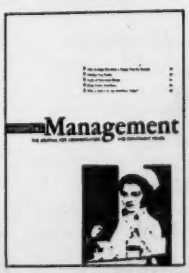

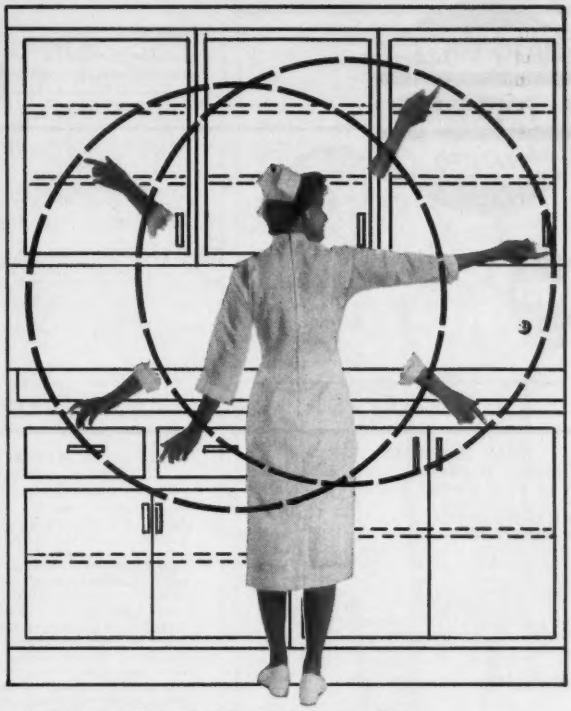

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Keeping the nurses' work load in mind and designing equipment to minimize it is one of the fundamental requirements of Maysteel "Hospital Designed" Casework.

Reach planning is one of these work-saving, step-saving, fatigue-saving features. For instance, in the illustration above, you notice that cabinet door pulls and drawer handles can be reached without the effort of squatting, bending, stretching or turning. Counter and working surfaces are built to average-height for minimum fatigue, and greater convenience. The highest shelves are brought down to easy reach from floor level with no loss of storage area.

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ADMINISTRATORS: (a) 700 bed general hospital. Position second to the Medical Superintendent of the hospital and requires a broad knowledge of all phases of administration. (HM-3329). (b) Clinic. Middle West. 20 man group-very progressive. (HM-3305). (c) 50 bed hospital located on the shores of Lake Michigan in beautiful scenic area. Small town close to several cities. (HM-3109). (d) East. 160 bed hospital near New York City. (HM-3425). (d) East. 60 bed hospital built in 1951, fully accredited. (HM-3313).

DIETITIANS: (a) Chief. New 110 bed hospital near Chicago. Excellent opportunity. $6000 minimum. (HM-3368). (b) Teaching. School of Nursing, approved 250 bed hospital. $4800 minimum. (HM-3419). (c) Dietary Consultant. State Department of Mental Health. Plan and organize work in 4 hospitals. Some traveling within state. $6500 plus expenses. (HM-3387). (d) Chief. East. 150 bed hospital near Boston. Decentralized dietary program. $5500 plus 3 room apartment and garage. (HM-2958). (e) Chief. East. Within easy commuting of N.Y. City. 280 bed hospital $6500. (HM-3053). (f) Middle West. Assistant Director of Dietetics. (500 bed hospital in city of 120,000. Will have full responsibility for a full half of the dietary program. Capable of taking full charge at times. $7000 minimum. (HM-2968). (g) Chief. 500 bed university teaching hospital-3 kitchens. 9 dietitians in dept. plus a very capable staff of cooks, etc. $7000. (HM-3331).

NURSE ANESTHETISTS: (a) Calif. Man. Group of six physicians. 30 hour week. Excellent working conditions. $7200. (HM-2855). (b) South. 40 bed hospital in lovely small town close to several large cities. $7500 plus maintenance. (HM-3014). (c) Florida. 250 bed hospital. 5 nurse anesthetists in dept. $7200. (HM-3335). (d) Northwest. 40 bed hospital. No. O. B. Plenty off duty time. Town of about 15,000 in scenic area. Very popular vacation country. $7200 to $8400. (HM-3324).

DIRECTOR OF NURSES: (a) Director of Education. East. To establish a School of Practical Nursing in a 200 bed hospital located in college town of about 15,000. $6000 to start. (HM-3437). (b) California. Direct entire nursing program in 130 bed new general hospital part of which is still under construction. Good opportunity. $6000 plus apartment and meals. (HM-3181). (c) Director of Nursing Service. Middle West. New 110 bed hospital to open soon. Need Director now. $7200 minimum. (HM-3367). (d) Middle West. Organize, coordinate and direct entire nursing program — 254 employes. 225 bed teaching hospital expanding to approximately 300 beds. To $8500. (HM-3063). (e) East. Complete responsibility for nursing service department of about 450 employes giving service to average of 425 patients per day. 475 bed general hospital. To $8000. (HM-3347).

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Miss Elsie Dey, Director

ADMINISTRATOR: 50 bed hospital, Pennsylvania; modern building. (b) 100 bed Ohio hospital. (c) 81 bed Illinois hospital. (d) Small western hospital. (e) New hospital under construction, Michigan. (f) R.N.; Small western hospital. (g) 30 bed convalescent hospital, New York State. $400, board.

DIRECTOR OF PERSONNEL: 225 bed hospital, Pennsylvania. (b) Office Manager. 125 bed eastern hospital. (c) Credit-Collection Manager; 300 bed Ohio hospital. (d) Accountant; 250 bed eastern hospital.

ADMINISTRATIVE ASSISTANT: 400 bed mid-western hospital. (b) 200 bed California hospital.

DIRECTORS OF NURSING: $6500-$9,000. Mid-west.

ANESTHETISTS: Private Clinic, Ohio. $500; attractive fringe benefits. (b) West. $600.

TECHNICIANS: Laboratory. (Chief) Degree. $600. (b) Laboratory and X-ray. Private clinic, Ohio. (c) Physiotherapists.

EXECUTIVE HOUSEKEEPER: 300 bed hospital, New Jersey. (b) 400 bed hospital, university city, west. (c) 150 bed new hospital, Ohio. (d) New York State. $375.

POSITIONS WANTED

ADMINISTRATOR: R.N., Pa. M.S. Degree, Hospital Administration. 2 years Business Manager, large eastern hospital.

COMPTROLLER: Degree in Accounting. 4 years experience. Presently with large Ohio hospital.

BUSINESS MANAGER: B.B.A. Degree, 1945. C.P.A. 10 years Public Accountant. 4 years Assistant Comptroller, 200 bed eastern hospital.

ADMINISTRATOR: 48 years. 10 years experience Administrator, private medical clinic and 150 bed eastern hospital. At present hospital consultant; interested in directing expansion program.

DIRECTOR OF NURSING: B.S. Degree. 10 years Director, Nursing Service, 150 bed eastern hospital. 3 years Assistant Superintendent.

MAINTENANCE DIRECTOR: Extensive engineering experience, U.S. Navy. 4 years Engineer, large eastern organization. Any location.

EXECUTIVE HOUSEKEEPER: Course in Institutional Housekeeping. 3 years Assistant in large Illinois hospital. Desires advancement.

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ADMINISTRATIVE POSTS: (j) Adm Asst; MHA; 325 bd, vol, genl, JCAH hsp, adding 70 bds; $7,000 sal & fringe benefits; E. (k) Clinic grp; 15 Dr. clinic grp; pref one trnd clinc adm; MW. (l) Purchasing Agent; 300 bd, vol, genl, fully-apprvd hsp; sal open; min $6,000; lge univ city, E.-So-Central.

DIRECTOR OF NURSES: (m) 185 bd hsp, opening Fall '59, will expand to 400 bds; also plan schl of Nursg, etc; salary open; excl personnel policies; MW. (n) 725 bd. genl, fully-apprvd hsp; $8,500-$10,000; city 75,000, Calif.

EXECUTIVE HOUSEKEEPERS: (o) One qual'd reorganize dept; large, genl, fully-apprvd hsp; sal about $400 mo; univ med cntr, MW. (p) Able organize dept & train efficient workers; 200 bd, psych institution; sal open; near NYC.

NURSE ANESTHETISTS: (q) New, sml, genl hsp, doing quite a lot of surgery; offer up to $750 mo plus extra for calls after 40 hr wk; South.

PHARMACISTS: (r) Chief; man or woman; 450 bd, genl, fully-apprvd hsp w/active rsrch prog & serving as tchg cntr; sal open; univ city, E.

PHYSICAL THERAPIST: (s) Organize and run new dept, unlimited oppor for growth & develpt; 240 bd, JCAH, genl hsp; resort city, New England.

POSITIONS WANTED

ADMINISTRATOR: Mid 30's; FACHA; MBA, Hosp Adm, Univ Chgo; 10 yrs, unusually substantial administrative exper, incl'd'g past 5½ yrs as superintendent, 300 bd Eastern hsp; seeks university affiliated hosp or top caliber institution interested develop such affiliation; dynamic, enthusiastic individual; recommended without reservation.

ANESTHESIOLOGIST: Passed Part I; now completing military obligations; seeks assn w/Anes, hospital practice; Age 28.

PATHOLOGIST: Diplomate, clin-Anat-Neuro Path; 20 yrs, Navy Path, Chief positions 1 yr, Chief Path, excl hsp; seeks Chief-hp, genl hsp; Age 44.

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For confidential, competent service, EMPLOYEES & EMPLOYERS are invited to contact Dr. A. H. Hammond, **NATIONAL SCIENTIFIC PERSONNEL BUREAU, INC.,** Box 2707, Wash. 13, D.C.

DIRECTOR OF NURSING SERVICE: Present director retiring. Well organized department of nursing, enjoys excellent rapport with other departments. J.C.H.A. approved hospital, 289 adult beds, modern plant and equipment. Located in picturesque Kanawha Valley. No School of Nursing at present. Prefer candidate with Master's degree and some experience either as director or assistant. Progressive attitude on salary, 3 weeks paid vacation, sick leave accumulative to 30 full and 60 half days. Truly a desirable position. Write H-23, HOSPITAL MANAGEMENT.

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NURSE ANESTHETIST: For 143 bed general hospital in East Tennessee. Beginning salary $450.00 per month and full maintenance with increase to $500.00 per month with fringe benefits of holidays, sick leave, and vacation. Write Mr. W. W. Fanning, Adm., BRISTOL MEMORIAL HOSPITAL, Bristol, Tennessee.

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Metropolitan Medical Center Responsible for planning, budget, supervisor of maintenance operators.

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This excellent opportunity is restricted to candidates of proven ability.
Send complete resume of education and experience as well as recent photograph to BOX H-20, HOSPITAL MANAGEMENT.

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MISCELLANEOUS

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He was driving through New Hampshire one summer day when his car broke down. Trekking over to a near-by farmhouse, he approached a man rocking on the porch.

"My name is Caruso," he said. "Have you a phone?"

The farmer leaped to his feet and started shaking him by the hand. "Well, I never thought I'd have anybody so famous in this little farmhouse," he said, then called into the house, "Hey, Emma, come out, quick!"

His wife appeared in the doorway. "Emma," said the beaming farmer, "I want to introduce you to the world-famous traveler, Robinson Crusoe!"

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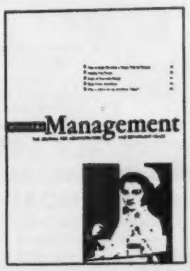

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by **E. M. Bluestone, M.D.**

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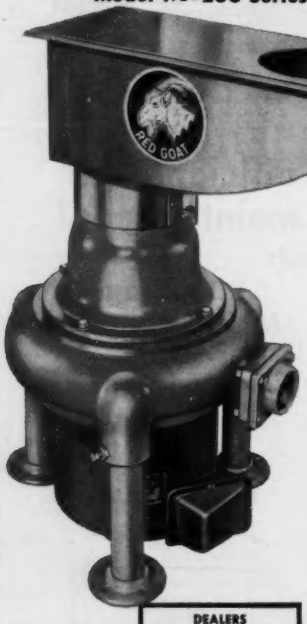

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RESTAURANTS and CAFETERIAS

To Provide Point of Origin Waste Disposal Stations

We had to do it! Yes, restaurant and cafeteria owners forced us to build a smaller capacity disposer with the same high-speed disintegrating action as the famous RED GOAT 5-100. Here it is! . . . the RED GOAT, JR. . . . another rugged, low-maintenance machine for the instant disposal of all types of waste — food, bones, fibrous material, fruit pits, paper napkins, plates, and cups. Write today for descriptive literature.

- RUGGED CONSTRUCTION
- ONLY ONE MOVING PART
- NO KNIVES OR CUTTERS TO JAM
- SAVES TIME AND MONEY IN WASTE HANDLING
- GREATER CAPACITY AND SPEED
- NEW JET-WATER FEED with SILENCING WATER CURTAIN
- EASY TO INSTALL
- MINIMUM MAINTENANCE

DEALERS

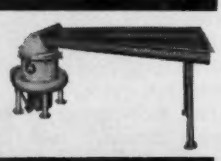
Write for complete information on territories available for RED GOAT Dealerships.

For LARGE VOLUME INSTANT DISPOSAL of FOOD and PAPER WASTE

The Powerful RED GOAT 5 H.P. and 7½ H.P.

Designed expressly for instant disposal of waste in high volume feeding establishments, these RED GOAT models include all features of RED GOAT, JR. plus extra capacity and speed of disposal.

Available with sorting table, as illustrated, or for under table installation. Write for descriptive literature on the complete line of RED GOAT Commercial Waste Disposers.



THE COLERAIN METAL PRODUCTS COMPANY

DEPT. EE, 2021 EASTERN AVENUE • CINCINNATI 2, OHIO

Every philanthropist is a taxpayer but every taxpayer, alas, is not a philanthropist.

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When medical care in the home, at any age, becomes unbearable only because of the multiplicity of household chores (and this holds for the continued care of the normal aged with their families) outside help should be brought in for the chores in preference to the institutional transfer of the problem.

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The institution known as the modern hospital has not been created for the purpose of relieving the family of a burden which can be tolerated, with or without home-help from the outside.

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A geriatric patient is one whose dependence on his fellow-men is due to his age as well as his illness.

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The management of a patient, whether it be based on medicine or surgery, is, in effect, the soul of hospital administration expressed in terms of action. It involves the ability of the hospital to make its overall administration a combination of individual services, without favoritism, generalization or false economy.

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Hospitals are becoming increasingly money-conscious, and too often for good reason. But I remind you here, among other things, that it is better to have vacancies than to have a waiting list, and better to err on the side of excess rather than on the side of deficiency.

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A "bread-line" in the waiting room of the Out-Patient Department is proof positive that this section of the "modern" hospital has missed an important therapeutic advantage.

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If you mix efficiency with inefficiency the product causes administrative headaches.

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If I had my way, every hospital which does not have a Division of Social Medicine would invite the head of the Social Service Department to sit on its Medical Board.